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Effect of an Individualized Treatment Protocol on Competency Restoration in Pretrial Forensic Inpatients.

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**EFFECT OF AN INDIVIDUALIZED TREATMENT PROTOCOL ON
COMPETENCY RESTORATION IN PRETRIAL FORENSIC INPATIENTS**

A Dissertation

**Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy**

in

The Department of Psychology

by

Lisa Jo Bertman

B.A., Newcomb College of Tulane University, 1989

M.A., Louisiana State University, 1994

December, 1999

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Abstract

Competency to stand trial refers to a defendant's ability to consult with his attorney with a reasonable degree of factual and rational understanding of the proceedings against him. If declared incompetent to stand trial by the courts, judicial proceedings are postponed until a defendant's competency deficits are remediated. However, there is a paucity of data on treatment of individuals who have been declared incompetent to stand trial. This study evaluated the effectiveness of individualized treatment on competency restoration in pretrial patients. This investigation improved upon previous group treatment studies, all but one of which were uncontrolled. Treatment groups were: Deficit-Focused Remediation - DFRT (6 individual sessions + 4 group sessions; N=8), Legal Rights Education Control - LRE (6 individual sessions + 4 group sessions; N=10), and Standard Hospital Treatment - SHT (4 group sessions; N=8). Results indicated no significant baseline differences among groups. All groups differed significantly from pretest to posttest on competency measures. The DFRT and the LRE groups both demonstrated significantly greater post-treatment scores on competency measures than the SHT group. Both groups demonstrated approximately 50% more improvement on the competency measures than the SHT group. There were no significant differences between the DFRT and LRE groups on post-test competency scores, indicating that focus on individual deficits is not a useful treatment strategy. Results demonstrate more frequent individualized legal rights education is a worthwhile endeavor in treatment of incompetency. Limitations and parameters of this study as well as applications and future directions are discussed.

Introduction

Background on Pretrial Incompetency

As many as 9,000 inpatient beds are reserved nationwide for individuals who have been adjudicated incompetent to stand trial (Davis, 1985). This population constitutes the largest proportion of psychiatric patients committed to mental hospitals via the United States criminal justice system, comprising approximately one-third of all admissions to state and federal mental health facilities (Pendelton, 1980; Brown, 1992).

Pre-trial incompetency is a legal doctrine adopted from English common law (Grisso, 1988). For centuries, courts were concerned about the ability of certain defendants to meaningfully participate in a trial. These concerns centered around the idea that a defendant should have both a fair and an accurate trial. The term “competency” at this time was defined generally, and held that the defendant must have the capability to adequately defend himself against his accusers (Lipsitt, Lelos, & McGarry, 1971).

The modern legal definition of competency to stand trial is taken from the U.S. Supreme Court landmark case of *Dusky v. United States*. In this case, the court operationally defined competency, indicating a defendant must have “sufficient present ability to consult with his attorney with a reasonable degree of rational understanding” and “a rational as well as factual understanding of the proceedings against him” (1960). The doctrine of competency exists to ensure fairness of the trial process. If a defendant is incompetent, treatment is necessary to help remediate deficits in the abilities defined by Dusky. Dusky refers only to

present competency ability and does not reflect or represent the person's ability or mental state at the time of the offense (i.e., the insanity defense).

The most common reason for deficits in pre-trial competency abilities is psychotic symptoms and mental retardation, with the former being most frequent (Grisso, 1988; Nicholson & Kugler, 1991). Mental illness does not, however, equal legal incompetency. For example, while schizophrenia and mental retardation are the most frequent diagnoses among incompetent defendants (34% and 16%, respectively), only approximately one-half of schizophrenic defendants and one-third of mentally retarded defendants are declared incompetent to stand trial (Grisso, 1992). Thus, the mere presence of a mental disorder clearly does not preclude a defendant from being competent, or from being restored to competency (Davis, 1986). If a defendant with mental illness is able to understand the nature of the proceedings against him, and is able to assist counsel in his defense, the defendant may proceed to trial (Grisso, 1988; Robey, 1965). Likewise, a diagnosis of mental retardation is not always sufficient grounds to declare an individual incompetent. As the intellectual level required by the courts for pretrial competence is not very high, individuals with mild mental retardation (IQ = 55-69) often go to trial (Robey, 1965). In addition, it is assumed that incompetence is not a permanent or intractable condition. Therefore, individuals who are incompetent to stand trial may be provided treatment to remediate the deficits in abilities defined by Dusky. If the defendant has a behavioral, psychological, or medical condition which affects his competency abilities, this condition should be treated adequately to allow remediation of the deficits in competency abilities (Grisso, 1988).

Once a defendant has been declared by the court to be incompetent to stand trial, judicial proceedings are postponed until deficits in competency abilities are remediated. Until 1972, there was no statute of limitation on how long a defendant could be held for treatment. The Supreme Court decision in *Jackson v. Indiana* determined that a “defendant found incompetent to stand trial cannot be held for treatment indefinitely; there must be a prospect for successful treatment within a reasonable period of time” (1972). A “reasonable period of time”, however, was not explicitly defined. Thus, the primary goal of the court is not only to remediate the defendant’s deficits in competency abilities, but to do so in an expeditious manner. It is in the defendant’s best interest to be restored to competency as quickly as possible to prevent a protracted involuntary hospitalization (Davis, 1985). The central benefit of returning to stand trial would be a release from involuntary incarceration (if found innocent, found guilty and placed on probation, or found guilty and released based on time served); or, if found guilty and sentenced to prison, the potential to receive ‘good time’ while in the Department of Corrections and released from involuntary incarceration in as little as one-half the time he could be held in a forensic hospital (this would apply primarily to minor violations). If a defendant is not found competent to stand trial, he may be hospitalized for a period which exceeds the length of time he would serve for his charge (*Jackson vs. Indiana* notwithstanding).

Assessment of Pretrial Incompetency

Most literature on pre-trial patients has focused on the assessment of competency to stand trial. Although the final decision of competency is a legal one, the determinations made by the court are largely based on competency

evaluations and recommendations made by mental health professionals (Roesch, Ogloff, & Golding, 1993). There are three errors commonly made in the assessment of pretrial incompetency: 1) Professionals confuse the issue of pretrial competency with that of criminal responsibility (e.g., sanity vs. insanity); 2) Professionals assume mental illness equals incompetency; and 3) Professionals fail to provide detailed or relevant reports (i.e., information related to legal competency) (Elwork, 1984). The latter problem is due in large part to the reliance on traditional psychological assessment methods rather than using measures specifically designed to assess competency (Grisso, 1986).

In response to criticism surrounding assessment procedures, several instruments have been developed specifically to address competency related issues. For example, the Interdisciplinary Fitness Interview (IFI) was designed to provide a comprehensive assessment by focusing on a defendant's competency while also taking into account mental health issues (Golding, Roesch, & Schreiber, 1984). This semi-structured interview is to be given collaboratively by a mental health professional and a lawyer. While initial interrater reliability of this instrument was good (97% agreement on final judgments), the data must be interpreted with caution because of small sample size. In addition, the IFI seems somewhat impractical because it requires a collaborative effort between two professions who are unlikely to be employed jointly. The Competency Assessment Instrument (CAI) is another semi-structured interview which provides suggested interview questions and allows for a flexible interview format and structure (McGarry, 1973). Accordingly, examiners frequently do not utilize the rating system for the CAI (Grisso, 1988). While this flexibility may be useful for certain purposes,

reliability of this instrument may be compromised. In fact, there is little information available on the reliability and validity of the CAI (Golding et al., 1984). Another assessment instrument, the Computer-Assisted Determination of Competency to Proceed (CADCAMP), addresses competency issues as distinct from criminal responsibility (Barnard, Thompson, Freeman, Robbins, Gies, & Hankins, 1991). This 272-item interactive computer-based assessment device was designed to collect data relevant to competency directly from a defendant (Barnard, Nicholson, Hankins, Raisani, Patel, Gies, & Robbins, 1992). The items elicit information about a variety of domains including the defendant's background characteristics. Although the CADCAMP has promising reliability data and interrater agreement of 88% for decisions about competency to stand trial, the testing process takes 1 - 2 hours to complete, requires computer equipment, and necessitates screening to determine if patients can read at an appropriate level.

The IFI, the CAI, and the CADCAMP are innovative and potentially useful instruments, however, the most commonly used measures are the Competency Screening Test (CST) and the Georgia Court Competency Test - Mississippi State Hospital Revision (GCCT-MSH), largely because of their simplicity, standardized administration, demonstrated interrater reliability ($r = .94$ and $.95$, respectively) and predictive validity (73.6% and 85.4% hit rates) (Nicholson, Briggs, and Robertson, 1988; Ustad, Rogers, Sewell, & Guarnaccia, 1996; Lipsitt, Lelos, & McGarry, 1971; Nicholson, Robertson, Johnson, & Jensen, 1988; Nottingham & Mattson, 1981). The GCCT-MSH, however, has shown a more replicable and clear internal factor structure, and has been recommended for use over the CST for this reason (Nicholson et al., 1988).

In addition to developing reliable and valid measures, researchers have emphasized the purpose and goals of competency assessment. Assessment of competency should describe the defendant's strengths and deficits based on the criteria outlined by Dusky (Grisso, 1988). Specifically, this goal may be attained by focusing the assessment on the following functional areas: 1) Knowledge and appreciation of the present charge; 2) Knowledge and appreciation of the possible consequences; 3) Ability to have an appropriate relationship with an attorney; 4) Knowledge of courtroom procedures; and 5) The capacity to integrate and efficiently use knowledge and abilities in either a trial or plea bargain setting (Davis, 1986; Maloney, 1985). When conducting evaluations for competency, questions about the patient's mental state at the time of the alleged crime are irrelevant and may be misleading; assessment of the defendant's current mental status, however, is relevant and helpful.

Treatment of Pretrial Incompetency

The treatment of incompetent defendants was a largely neglected area until the late 80s (Grisso, 1992). Most investigations over the past five years have focused on the ability of professionals to predict which defendants will regain pretrial competency based on demographic variables (Cooper & Grisso, 1996). For example, Carbonell, Heilbrun, & Friedman (1992) attempted to predict who would regain competency in a sample of incompetent defendants. Predictor variables used were demographics, education, IQ, criminal history, psychopathy, other psychopathology, and perceptual-motor dysfunction. Accurate prediction occurred in 72.2% of cases, but dropped to 59.9% in the cross-validation sample leading the authors to be pessimistic about the ability to accurately predict who

will regain competency as determined by the court. Other studies have also had discouraging results with regard to prediction of competency restoration (Nicholson & McNulty, 1992). This is due primarily to the low base rate of failure to restore competence (it has been estimated at 10%) (Nicholson et al., 1992; Nicholson, Barnard, Robbins, & Hankins, 1994). Nicholson et al. (1994) did, however, find that knowledge of adversary process, appropriate courtroom behavior, and severity of psychopathology scales from CADCOMP were significantly correlated with competency restoration (.19, .27, and .34, respectively) and length of hospital stay (.28, .19, .20, respectively), although they recommend that mental health professionals be guarded in their feedback to the courts with regard to competency restoration outcome and length of hospitalization required.

Given that the base rate of failure to restore competence is so low, it would seem worthwhile to dedicate more time to better understanding and improving the treatment of incompetency rather than on predicting clinical outcome. Few forensic hospitals, however, have outlined and tested the treatments employed by their facility, and only one controlled treatment study exists to date (Siegel & Elwork, 1990). In developing a treatment plan for incompetent defendants, both earlier and more recent literature agree that the treatment objectives should focus on the issues directly related to restoration of competency (Pendelton, 1980; Davis, 1985; Brown, 1992). However, most forensic facilities do not provide treatment services above and beyond what is offered to mentally ill patients who are civilly committed, i.e., forensic hospitals infrequently provide treatment specifically geared toward restoring competency, and most programs

typically depend on psychotropic medication for treating patients who are incompetent to stand trial (Carbonell et al., 1992; Roesch & Golding, 1987).

Pendelton (1980) first described a treatment program for incompetency at Atascadero State Hospital. In this program, patients were first treated for symptoms which interfered with standing trial. This was usually accomplished by establishing a psychotropic medication regimen. After symptoms were reduced, the patient entered a group competency class where the following areas were discussed: Pleas entered in court, roles of courtroom personnel, courtroom procedure, and appropriate courtroom behavior. If the patient scored a 70% on the final exam pertaining to this class, he began participating in a videotaped mock trial whereby he was exposed to a simulated courtroom situation. Patient performance for this portion of the treatment was scored either pass or fail. Following this final phase of treatment, the patient was reassessed to determine whether he was ready to return to court. Treatment outcome data revealed that 90% of these pretrial patients were able to return to court and 97.5% successfully completed the trial process. The average duration of treatment before the patient received competency certification was 104 days. While these outcome data seem outstanding, this was not a controlled study, making it difficult to attribute treatment success to the treatment program. Furthermore, the multifaceted program makes it unclear as to which component(s) of the program were necessary and which were most successful. Finally, no information was given about interrater reliability. In an end note, the authors state, "It is our hope that eventually controlled studies may be undertaken..." in the area of competency restoration (p. 1100).

Davis (1985), in his treatment program, segregated his patients into the following six small groups based on their specific needs or deficits: Advanced-maintenance, psychotic-confused, low functioning, delusional-irrational, disruptive, and requiring tutoring or requiring individual competency counseling. This latter group was individualized and was designed to discuss behavioral and situational specifics with selected patients. In addition to targeting the problems specific to each group, Davis (1985) noted that treatment plans for all patients should address the same five functional areas which he recommends also be specifically addressed in the assessment procedure: Knowledge of the charge, knowledge of the possible consequences, the ability to rationally communicate with an attorney, knowledge of courtroom procedures, and the capacity to integrate and efficiently use knowledge and abilities in either a trial or plea-bargain setting. Treatment for each group also included participation in a mock trial situation. This study shares the same weaknesses as that of Pendleton (1980). Additionally, the author did not describe how patients selected for individual treatment were chosen, only that group intervention was not appropriate for certain patients. Finally, because they did not present any statistics, there is still considerable question as to whether or not this treatment works.

A more recent study outlined a didactic group program for incompetent patients (Brown, 1992). Following treatment for acute psychiatric symptoms (i.e., psychotropic medication), individuals attended five, 30-45 minute group sessions per week. There were between 6 and 14 patients per group. Topics discussed in group were: Classification of criminal charges and sentences, the elements of specific charges, roles of the participants in the trial process, the sequence of

events in a trial, and the consequences of pleas, verdicts, and sentences.

Participants received information about their rights, and about cooperating with their attorney. They also watched videotaped role play among legal representatives and took two short tests. The authors reported treatment success, but provided no outcome data for their uncontrolled, anecdotal report of their treatment program.

In summary, while each of these treatment programs is unique, the non-experimental nature of their protocols makes it difficult to draw any conclusions about treatment efficacy. First, because these protocols were not compared to more standard, basic treatments, one cannot determine how effective they were relative to other treatments (e.g., restored patients to competency faster or restored more patients to competency). Second, the published reports of the treatment programs gave little information about frequency, intensity, and duration of the treatment which makes any attempt at replication difficult. Finally, each treatment protocol was multifaceted, making it impossible to isolate the effective component(s) of any of these programs.

To date, there has been only one published experimentally controlled treatment study on competency restoration (Siegel & Elwork, 1990). This investigation was conducted to determine the efficacy of a treatment targeting trial incompetency issues. In this study, two interventions were implemented: 1) A cognitive, problem-solving group to facilitate factual and rational communication with attorneys and understanding of possible outcomes of trials; and 2) a psychoeducational treatment employing a videotape, a model of a courtroom, and a discussion of procedures and roles of persons in the courtroom. A total of 41

male defendants adjudicated incompetent to stand trial were included in an experimental/control group design. Following pretest of competency level with the Competency Assessment Instrument (CAI), the subjects were divided into experimental or control groups in a matched-subjects assignment procedure that equated subjects on baseline competency scores. Baseline testing was conducted for two sessions over a two week period. Group treatment was held three times per week for a total of nine sessions. The experimental group ($N = 21$) received the above mentioned interventions. The control group ($N = 20$) experienced the same treatment format, but the focus of these sessions was on basic psychiatric needs (e.g., dealing with anger and depression, surviving prison life, and the effects of drug use). Posttesting was conducted with the CAI following treatment. Results indicated no significant pre-treatment differences between the two groups in CAI means or demographic variables. The experimental and control groups showed a statistically significant difference between the pre and posttreatment CAI mean scores. This difference was attributed to the experimental condition. Additionally, the authors conducted an analysis of hospital staff competence recommendations to the courts. Forty-three percent of the experimental group was judged competent to proceed to court at 45 days posttreatment while only 15% of the control group was deemed competent to stand trial. These results suggest that forensic hospitals should pay more attention to the specific issues relating to competency during treatment.

This investigation, although well designed and controlled, shares some of the problems identified in the uncontrolled treatment protocols, as well as some additional difficulties. As stated above, the authors used scores on the CAI as their

dependent measure, and modified this instrument by rewording questions and/or making them open ended. Accordingly, it is not possible to determine the reliability and validity of this modified CAI. Again, the authors state a limitation to their study is its multifaceted nature. They not only used education, but also problem solving, video taping, a model of a courtroom setting and structured group therapy. Another shortcoming of this study is its failure to discuss the length of hospitalization prior to inclusion in the study; it is unclear if patients received some form of competency restoration treatment before the study began.

All of the above studies employed a group treatment protocol, with the exception of additional individual training in the Davis study, with some select patients. Group treatment, though, may not be the most effective way to help these individuals because legal problems, knowledge deficits and learning styles vary among individuals (Davis, 1985). A group setting is not an appropriate place to address individual charges or deficits as this information is confidential and cannot be shared with other patients without prior, informed consent; this type of discussion, however, may be what these defendants need to rapidly improve their understanding of the charges against them and their ability to assist their attorney.

Study Rationale

The purpose of the study was to evaluate the effectiveness of an individualized treatment protocol on competency restoration in pretrial patients. The study compared three conditions: 1) Deficit-Focused Remediation Treatment (DFRT), 2) Legal Rights Education Control (LRE) and 3) Standard Hospital Treatment (SHT). The DFRT group offered six individual competency restoration sessions to the patient, in addition to four legal rights education group sessions.

These individual sessions targeted competency deficits specific to the patient determined during assessment, and included discussion of the patient's legal charges, their meaning and their possible consequences. The LRE Control group received the same number of individual sessions (total = 6) and legal rights education group sessions (total = 4) as the DFRT group, but the individual sessions only discussed general legal rights issues. The SHT group received weekly legal rights group sessions (total = 4) and medication management which is standard treatment at the hospital. The four legal rights education group sessions were the same for all groups; that is, each group experienced this treatment.

The investigation attempted to improve upon the previous competency restoration studies because this controlled study consisted of a treatment group and two different control groups, allowing more comparison conclusions to be drawn about treatment efficacy. First, comparison of the DFRT and the LRE groups with the SHT group attempted to help delineate whether more frequent individual attention resulted in significantly greater scores on measures of competency. Second, by comparing the DFRT group with the LRE group, both equal in frequency of individual attention, it was determined whether treatment effects were due to differences in content. Specifically, whether discussion of individual issues and deficits led to greater scores on competency evaluations than discussion of general legal rights issues.

The goal of this study was to develop an educational program that would allow participants to 1) remediate individual deficits related to knowledge of the legal system; 2) understand the relevance of legal proceedings to their situation, and 3) generalize this knowledge to the actual courtroom proceedings. From a

theoretical perspective, the rationale for conducting a deficit-focused remediation treatment and hypothesizing that this group would outperform the control groups is best explained by the literature on transfer of training. Transfer of training refers to how what is learned in one setting transfers to another setting (Goldstein & Musicante, 1986). Transfer can be positive, negative, or nonexistent. Positive transfer, broadly defined, refers to the degree to which individuals apply knowledge and skills learned in one context to another situation (Witherington, 1952; Baldwin & Ford, 1988). More specifically, positive transfer occurs when initial training benefits performance on a second task relative to a control group (Goldstein, 1993; Gick & Holyoak, 1987). Likewise, negative transfer occurs if the performance on the second task is significantly worse in the experimental group than in the control group (Goldstein, 1993). No significant difference between the experimental and control groups on the second task is referred to as nonexistent or zero transfer. Transfer of training may be defined in many ways, but is most frequently regarded in terms of two conditions of transfer: 1) The generalization of material learned; and 2) The maintenance of this knowledge over time (Baldwin & Ford, 1988). Both conditions of transfer were relevant to the proposed study, but generalization of knowledge and skills was the most important goal of this educational program. Generality refers to the meaningfulness of interpretations of the experiment under circumstances that are different from those that generated the data (Johnston & Pennypacker, 1993). In terms of this study, generalization would be achieved if a participant became capable of transferring the information learned in the individual educational sessions to the post-testing situation, and the actual courtroom situation which is different from those in which

he was first trained. It is important to distinguish between transfer and learning. Transfer is different from learning because in cases of transfer, the learning situation differs from the context to which what is learned is applied.

Obviously, training programs are interested in maximizing positive transfer, and there have been several theories that attempt to explain how transfer of training occurs. One theory that is generally accepted in the literature is the Identical-Elements theory which was originally proposed by Thorndike and Woodworth in 1901 (as cited in Goldstein, 1993). This theory proposes that there is a continuum of similarity between two situations, and the degree to which the two contexts are identical or similar will facilitate transfer of training. If stimuli and responses are identical in training and transfer, there should be high positive transfer. Likewise, transfer would be nonexistent if the stimuli and responses are completely different in the training and transfer situations. The most common case scenario in training programs is that the stimuli are somewhat different in the training and transfer tasks but the responses are the same in the two situations. This paradigm predicts positive transfer because the individual can generalize material learned from one setting to another. In this study, the above paradigm applied to the DFRT group. The control groups, however, contained different responses between the training and transfer situations because the transfer situation addressed individual specific knowledge whereas the training situation did not.

In addition to understanding how transfer occurs, it is important to recognize that there are many conditions which affect transfer (Gist, Bavetta, & Stevens, 1990). The area affecting transfer which is most relevant to the current

study is the content of the training situation. In the DFRT group, the content of the training was designed to maximize the likelihood that the knowledge and skills learned would transfer. Because the actual transfer situations (the post-testing and the courtroom proceedings) were highly individualized, the training situation was formatted to address individual specific information and deficits. Therefore, the DFRT group was exposed to learning material that was more similar and readily applicable to the transfer situation than were the control groups. This information should have been more accessible, requiring less effort for the participant to recognize the applicability of their knowledge to the transfer situation. The control groups, however, had less practice with the responses required in the transfer situation, making it more difficult for participants to recognize similarities in the training and transfer situations.

In summary, based on this literature, it was hypothesized that individuals in the DFRT group would experience more positive transfer than the LRE and SHT groups. This positive transfer was measured in terms of significant differences among groups on post-test scores on the GCCT-MSH and the Bennett criteria. It was predicted that this positive transfer would also apply to the courtroom situation, though this was not measured in the current investigation.

Purpose

1) This study determined whether more frequent legal competency education training helped these patients attain significantly higher scores on the GCCT-MSH and the Bennett criteria, measures of competency to stand trial, than those who received training less frequently.

2) This study determined whether an individual training program targeting the specific legal competency deficits of the participant including understanding of the specific legal charges can help defendants attain significantly higher scores on the GCCT-MSH and the Bennett criteria than participants who received only general legal rights education.

Hypotheses

1) There will be significant within group pretest/posttest differences on the GCCT-MSH and the Bennett criteria for the DFRT group and the LRE Control group. There will be no significant within group, pretest/posttest difference in the SHT group on the GCCT-MSH and the Bennett criteria.

2) The DFRT and LRE groups will have significantly higher post treatment scores on the GCCT-MSH and the Bennett criteria than the SHT group.

3) The DFRT group will achieve significantly greater post treatment scores on the GCCT-MSH and the Bennett criteria than the LRE Control group.

4) As pretrial incompetency most often results from unremitting psychotic symptoms (Grisso, 1988), it is hypothesized that there will be a significant correlation between degree of treatment response in the DFRT and the LRE groups and BPRS change scores.

Method

Participants

The participant sample consisted of patients who were adjudicated incompetent to stand trial by the courts. This sample was drawn from Feliciana Forensic Facility (FFF) which is a maximum security hospital for the criminally insane located approximately 40 miles north of Baton Rouge. The participant sample consisted of 26 male patients, 8 of whom were in the Deficit-Focused Remediation Treatment group, 10 in the Legal Rights Education Control group, and 8 in the Standard Hospital Treatment group.

Participants met the following criteria in order to be included in the study:

- 1) Participants were between 18 and 60 years of age.
- 2) Participants had a four-subtest short form WAIS-R full scale IQ ≥ 60 .
- 3) Participants had an initial score on the Georgia Court Competency Test - Mississippi State Hospital (GCCT-MSH) of less than 70 and/or failed to meet the Bennett criteria of competency.
- 4) Participants were designated "standard" track by a multidisciplinary team. Patients who were placed in the "fast" or "Lockhart" tracks were excluded. "Fast" track patients are individuals who, upon admission, are deemed competent to stand trial. These patients are likely to be discharged from the facility within two weeks. A patient is placed in a "Lockhart" track when it is the clinical impression of a multidisciplinary team that he is unlikely to be restored to competency within a reasonable period of time (less than 180 days). Patients given a "standard" track status are deemed incompetent based upon initial

evaluation but will likely be restored to competency within a reasonable period of time. “Standard” track patients comprise approximately 90% of the Feliciana Forensic Facility pretrial population.

5) Participants had a baseline score on the Brief Psychiatric Rating Scale of ≤ 5 on all “Psychoticism” subscale items (i.e., hallucinations, unusual thought content, and conceptual disorganization).

6) Participants were not suspected of malingering. Malingering is suspected if a patient receives a score ≥ 6 on the “Atypical Presentation” scale of the GCCT-MSH. Additionally, participants were excluded if a malingering evaluation was requested from a psychiatrist independent of the Atypical Presentation scale score.

7) Participants were not facing first degree murder charges which could result in the death penalty.

8) Participants demonstrated an understanding of the purpose of the study, the requirements for participation, and the risk/benefit ratio by being able to answer questions on an informed consent validation questionnaire after the consent form was read to them.

No person was included in the study if he did not give voluntary consent. Confidentiality was maintained. Each participant was assigned a participant number. The master list matching participant names to participant numbers was protected by the examiner. Additionally, there were no invasive procedures, and at no time were the participants exposed to harm as a function of their participation in this study.

This proposal was approved by the Louisiana State University Institutional Review Board (IRB), the Feliciana Forensic Facility IRB, and the Office of Human Services IRB. There were no amendments to the research protocol during this study.

Setting

Feliciana Forensic Facility, a 236 bed maximum security hospital, was the site of the investigation. At the time of the proposal, a total of 82 inpatients at this facility carried a pretrial status, having been deemed incompetent to stand trial. Approximately 100 pretrial patients enter Feliciana Forensic Facility each year. Average length of stay for these patients was 112 days in 1994, 119 days in 1995, and 125 days in 1996. These statistics reveal a slight increase in hospital stay each year (approximately one week). The length of hospitalization appears to be average compared to other reports. For example, the shortest length of stay reported was by Nicholson et al. (1992) who found that their patient population stayed an average of 68.8 days, and that they showed significant improvement in psychiatric symptom severity over the course of their hospitalization. Most studies, however, have reported an average of 180 days for competency restoration (Rodenhauser & Khamis, 1988; Golding, Eaves, & Kowaz, 1989; Bennett & Kish, 1990). Rodenhauser et al. (1988) also reported a diagnosis of schizophrenia significantly increased length of hospitalization in their sample but did not decrease chances of being restored to competency. Approximately 75% of pretrial defendants admitted to Feliciana Forensic Facility within the last year were diagnosed with a psychotic disorder. The remaining 25% commonly carried a substance abuse diagnosis. Other DSM III-R and DSM-IV Axis I and/or Axis II

diagnoses observed in this non-psychotic population were: Exhibitionism, Malingering, Mental Retardation, Antisocial Personality Disorder, and Borderline Personality Disorder. The standard treatment protocol for the pretrial patient at Feliciana Forensic involves medication management as well as a 30 - 45 minute weekly group session of legal rights education conducted by the ward social worker.

Materials

Consent Form: The consent form outlined to the participants the reason for this investigation, and informs them of their legal rights as a research participant (See Appendix A).

Informed Consent Validation Questionnaire: Patients were asked questions to validate their understanding of the purpose of this study, the requirements for participation, and the benefit/risk ratio (See Appendix B).

Instructions to the Legal Rights Education Control group and the Deficit-Focused Remediation Treatment Group : A paragraph of instructions was read verbatim to the participants in the Legal Rights Education Control group and the Deficit-Focused Remediation Treatment group (Appendices C and D). These instructions reiterated the purpose of the study and indicated the time and effort required for inclusion in these groups. Additionally, these instructions made the participant aware that, by participating in this study, he may have been returned to court more quickly than if he did not participate in this study. It was explained to the participant that he would receive \$1.00 after the first week of treatment if he complied with participation, another \$2.00 after the second week of treatment if he complied with participation, and another \$3.00 after the third week of treatment

and post-testing. Participants were instructed not to discuss their participation in this study with other patients in order to minimize transfer of information outside of the treatment sessions.

Demographic Information Form: A demographic information form was completed for each participant (Appendix E). The majority of this information was obtained from the patient's hospital chart. Demographic information included the following: Age, race, marital status, education, current criminal charge(s), number of previous charges, employment at the time of offense, current medication(s), and whether the participant was using drugs at the time of the alleged offense. Axis I and Axis II diagnoses were also recorded based on psychiatrist and/or psychologist evaluation. A summary of the WAIS-R, BPRS, GCCT-MSH, and Bennett criteria scores was also included on this form.

Georgia Court Competency Test - Mississippi State Hospital Revision (GCCT-MSH): The GCCT-MSH is a 21 item measure designed to assess an individual's level of competency to stand trial (Wildman, 1978) (Appendix F). This test is administered verbally by an examiner. A factor analysis of the GCCT-MSH revealed 3 distinct factors: 1) General legal knowledge; 2) Courtroom layout; and 3) Specific legal knowledge (Nicholson, Briggs, & Robertson, 1988). The total score ranges from 0 - 100; there are different score weights applied to different questions. A score of 70 or greater is recommended for classifying defendants as competent, a score between 60 and 70 is considered marginal competence, and below 60 indicates incompetence (Wildman, 1978). The GCCT-MSH has demonstrated a stable factor structure across two samples (Nicholson et al., 1988; Bagby, Nicholson, Rogers, & Nussbaum, 1992). The GCCT-MSH has

also demonstrated good internal consistency (alpha coefficient = .88) and item homogeneity (Ustad, Rogers, Sewell, & Guarnaccia, 1996; Nicholson et al., 1988). Excellent interscorer reliability ($r = .95$) and criterion validity have also been established with this measure (Nicholson, Robertson, Johnson, & Jenson, 1988), as well as low false positive rates and objective scoring when compared to other measures (Ustad et al., 1996).

Clinical Judgment Using the Bennett Criteria: The clinician made a qualitative judgment regarding the participant's competency to stand trial based on specific Bennett criteria (Appendix G). The Bennett Criteria are derived from the *State v. Bennett* case which outlines areas the judge should consider while evaluating a defendant's ability to stand trial (1977). These criteria are organized into two broad classes: 1) The individual's overall ability to understand and appreciate the nature of the charges brought against him; and 2) his ability to assist counsel in his defense. The Bennett Criteria consist of 16 items representing the broad classes mentioned above. The items are scored "yes" or "no", where "yes" represents adequate competency in a particular area and "no" reflects incompetency. A score of 1 will be given for each item when the individual receives a "yes". Thus, a participant can have a total score between 0 and 16, with a lower score representing more deficiencies in competency. The Bennett Criteria are given in conjunction with the GCCT-MSH and assist the examiner in forming a clinical impression about whether or not the patient is competent to stand trial. The final Bennett criteria judgment will be either "yes, the individual is competent to stand trial" or "no, the individual is not competent to stand trial".

There are no reliability and validity data on this measure which is strictly a clinical impression about an individual's competency status.

Brief Psychiatric Rating Scale - Expanded Version (BPRS): The BPRS is a widely used standardized assessment tool for the description, measurement, and classification of psychiatric symptom severity (Overall & Gorham, 1962; Lukoff, Nuechtertein, & Ventura, 1986) (Appendix H). The Expanded Version consists of 24 items which are rated by the interviewer on a 7 point Likert scale where 1=not present and 7=extremely severe. Items 1-14 are rated based on the patient's self-report during interview. Items 7, 12, and 13 are also rated based on behavior observed during the interview. Items 15-24 are rated on the basis of observed behavior or speech of the patient during interview. The expanded version offers the advantage of standardized interview questions for eliciting psychiatric symptoms and detailed anchor points for rating each item (Lukoff et al., 1986). The BPRS is a widely accepted instrument with well established reliability and validity; interrater reliability estimates of .80 were identified in a review of 13 studies, and BPRS scores have consistently reflected treatment changes that are observed by other clinical measures (Hedlund & Vieweg, 1980). The demonstrated ability of the BPRS to assess symptom change during treatment makes this instrument one of the most important tools for measuring therapeutic effects (Ventura, Green, Shaner, & Liberman, 1993). The primary purpose of administering the scale for this study was to monitor symptom changes in these patients over the course of their treatment. Participants were asked to give self-report ratings for the time period of the past two weeks. A BPRS total score was used as a dependent measure. In addition, the BPRS Psychoticism Subscale was

used as an exclusionary measure. This subscale consists of the following items: Hallucinations, Unusual Thought Content, and Conceptual Disorganization. A score > 5 on any of these items resulted in dismissal from consideration in this study.

Weschler Adult Intelligence Scale - Revised (WAIS-R) Four Subtest

Short Form: This measure consists of the following four WAIS-R subtests: Vocabulary, Arithmetic (Verbal IQ), Picture Arrangement, and Block Design (Performance IQ) (Appendix I). The two verbal subtests and two performance subtests are the best predictors of total VIQ and total PIQ scores, respectively (Doppelt, 1956). This tetrad has shown .94 reliability coefficient with the Full scale IQ score (Kaufman, 1990; Doppelt, 1956; Silverstein, 1982). This instrument was used as an exclusionary measure; patients who obtained a full scale IQ equivalent < 60 were excluded from participation in this study.

Legal Rights Study Guide: This document is the standard legal rights protocol used for the weekly legal rights group at FFF (Appendix J). The guide was used as the treatment protocol for the four legal rights group sessions in all three conditions, and was also used during the six individual treatment sessions in the Legal Rights Education Control group. It contains information regarding the available pleas and verdicts, the consequences of each plea or verdict, patient legal rights, the layout of the courtroom, the duties of different professionals in the courtroom, assisting counsel, and plea bargaining.

Deficit Focused Remediation Treatment Program Checklist: The protocol incorporates major areas related to competency. These areas are taken directly from the GCCT-MSH and the Bennett criteria which are administered to the

patient pre-treatment. Information contained in these documents has been used to create a checklist pertaining to particular deficits experienced by patients (Appendix K). Any deficit that pertains to an individual was marked and remediation targeted only these particular deficiencies. Individual deficits were identified and addressed in each individual session. In addition, the participant's criminal charge(s), its meaning, and possible consequences were discussed openly in each session.

Therapist Evaluation Form: Participants were asked by the study coordinator to evaluate each therapist at the end of the treatment protocol (Appendix L). The following areas were rated using a 5 point likert scale: Friendliness, comfort level, trustworthiness, helpfulness of therapist, level of interest in patient treatment success, and therapist regard towards the patient (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985). The purpose of this evaluation was to ensure there were no significant differences in therapist variables between the treatment and control groups.

Debriefing statement: The debriefing statement outlined again to the participant the purpose of the study, and allowed for the patient to ask any questions (Appendix M). Questions and answers were recorded during debriefing and included in the patient's experimental data file. The participants were given information about how to contact the primary investigator should they wish to know the results of the study.

Design and Procedure

Upon admission to FFF, all routine assessments were conducted (e.g., nursing, social work, psychology, psychiatry), and incompetent patients were

administered a GCCT-MSH and were evaluated using the Bennett criteria, standard protocol at FFF. Based on the competency evaluation, patients were placed in one of three possible status tracks by a multidisciplinary team: Fast, Standard, or Lockhart. A “fast” track status reflected individuals who were deemed competent to stand trial upon initial evaluation. It is the goal of the facility to discharge these patients to the courts within two weeks of the initial evaluation. A patient was placed in a “Lockhart” track status when it was the clinical impression of a multidisciplinary team that the individual was unlikely to be restored to competency within a reasonable period of time. Patients placed on a “standard” track status are deemed incompetent based upon initial evaluation but will likely be restored to competency within a reasonable period of time. Only patients who receive a “standard” status were considered for participation in this study.

Approximately two to four weeks after the initial evaluation of competency, baseline measures were administered to all “standard” track patients. The rationale for this waiting period was two-fold. First, this time period allowed the participant to adjust to his new environment; and second, it usually takes approximately two weeks for individual dosing and titration of medication to be stabilized.

Baseline measures included a re-evaluation of competency with the GCCT-MSH and the Bennett criteria, the four-subtest short form of the WAIS-R, and the BPRS. Competency re-evaluations were administered by a psychologist or a psychology graduate student who was blind to the treatment condition of the patient. The four-subtest short form of the WAIS-R and the BPRS was

administered by an individual who was part of the treatment team (i.e., psychologist, psychology graduate student). Patients who received an estimated IQ < 60 on the four-subtest short form of the WAIS-R or who scored > 5 on any Psychoticism subscale items on the BPRS were excluded from participation. Additionally, patients who were suspected of malingering, as indicated by a score of ≥ 6 on the “Atypical Presentation” scale of the competency evaluation, were excluded from the study. Patients who did not meet inclusion criteria for this study received the standard hospital treatment, but were not included in the Standard Hospital Treatment control group.

A consent form offering the opportunity for participation was read to all patients who met inclusion criteria for this study. No patient was included in the present investigation unless prior, informed consent was obtained. Each patient was assured confidentiality, and a participant number was assigned. A master list matching each patient’s number to their name was in the primary investigator’s possession. Demographic information was obtained by chart review.

Patients who signed informed consent to participate were assigned to one of three conditions: The Deficit-Focused Remediation Treatment group (DFRT), the Legal Rights Education Control group (LRE), or the Standard Hospital Treatment Control group (SHT). Participants were assigned to these groups using a matched-subjects design procedure which was based on psychotic vs. non-psychotic diagnoses and GCCT-MSH scores. First, there was approximately (groups had unequal subject sizes) the same number of participants in both groups who had psychotic diagnoses, that is, the first patient was randomly assigned to one of these conditions; if he had a psychotic diagnosis, then the second patient

admitted to the study was placed in a different group if he carried a psychotic diagnosis. Archival data indicated at least 75% of pretrial patients would have a psychotic diagnosis, thus it was expected most participants would fall into this category. In this study, 77% of subjects carried a psychotic disorder diagnosis. Additionally, subjects were placed into groups based on GCCT-MSH scores which were divided into two categories to help ensure non-significant baseline differences: Category one referred to participants who scored < 60 on the exam; category two included scores ≥ 60 . Although it would seem logical that IQ is a variable in success of an educational program, patients were not be matched on IQ scores. The rationale for random assignment based on IQ comes after repeated assessment of IQ in the forensic population. Based on observation of IQ scores, there is little variability in Full Scale IQ scores in this population, with most patients scoring in the mild mental retardation and borderline ranges. A random sampling of Full Scale WAIS-R IQ scores of 90 patients at FFF (patients who scored < 60 were not included as this was one of the exclusion criteria for participation in this study) confirmed the notion of little variability in IQ. The average IQ score of the 90 patients randomly chosen was 71, with the lowest score at 60 and the highest score at 92. The standard deviation was 8.25 and standard error was .869. The mode was 66. Of this sample, only 10 patients scored ≥ 85 .

Participants received \$1.00 after week one of treatment, \$2.00 after week two, and \$3.00 after week 3 and post-testing, for a total of \$6.00. Payment was contingent upon required attendance.

Treatment Procedures

1) **Standard Hospital Treatment group:** Participants who were assigned to this group were administered the same screening procedures as the other two groups to ensure that an equivalent comparison sample was obtained (i.e., same inclusion/exclusion criteria, comparable baseline scores on the GCCT-MSH, IQ, and psychotic vs. non-psychotic diagnoses). Treatment of these patients included four weekly legal rights education groups offered by the ward social worker which last approximately 30 - 45 minutes.

2) **Legal Rights Education Control group:** Participants who were assigned to the Legal Rights Education Control group received two individual sessions per week for three weeks of Legal Rights Education training (6 training sessions). The areas discussed in these sessions followed the Legal Rights Study Guide protocol which includes: 1) The three possible pleas and verdicts, and their meaning; 2) The six legal rights of the defendant; 3) The layout of the courtroom; 4) The roles of different people in the courtroom; 5) Ways to assist counsel in the defense; and 6) Plea bargains.

During training, each therapist assistant attended at least two of the legal rights education group treatment sessions, conducted weekly on the ward in order to learn the material necessary for conducting the individual legal rights education sessions. The individual legal rights education sessions followed the format of this group, the content of which is described above. No specific information related to individual charges was discussed in these sessions, therefore individual specific information was not summarized. The treatment assistants followed the legal rights study guide during the sessions.

All of the above information was presented to the participant in question form in an attempt to elicit responses that reflected his current knowledge of general legal proceedings. If the participant clearly did not know the material, then it was presented to him. All information in this study guide was presented in each session which lasted approximately 30 - 45 minutes. In addition, these participants received four weekly legal rights education groups offered by the ward social worker which last approximately 30 - 45 minutes.

3) Deficit-Focused Remediation Treatment group: Participants who were assigned to the Deficit-Focused Remediation Treatment group received two individual sessions per week for three weeks of treatment for specific deficits (6 training sessions). Information presented in this treatment targeted the participant's particular deficits. Thus, the content of each session varied from participant to participant. The sessions focused on two major areas: 1) Open discussion of the defendant's specific charges, their meaning, and possible consequences. Information pertaining to these defendant specific areas was obtained by conducting a thorough chart review. This review summarized data related to the patient's psychiatric and criminal history, existing criminal charge(s), the meaning of the existing charge(s) and its/their potential consequence(s) (e.g., maximum years penalty), all details surrounding the charge(s) including time, date, site of event, mental status during this time, and, most importantly, witness and/or police reports; and 2) Remediation of the defendant's competency related deficits observed on the GCCT-MSH and the Bennett criteria pretest. Deficits were summarized into a checklist which described to the treatment assistants the specific areas which were to be targeted

during treatment with the specific defendant. The treatment assistants used this checklist as well as the summary of the chart review as a guide during the sessions. Additionally, the raw data from the GCCT-MSH and the Bennett criteria was accessible to the treatment assistants during each session if they wanted to use the actual answers given by the participants as a reference.

All of the above information was presented to the participant in question form in an attempt to elicit responses that reflected his current knowledge of the specific charge(s) and the legal procedures as they relate to his deficits. If the participant clearly did not know the material, then it was presented to him. All deficits were addressed in each individual session. If all information was presented before 30-45 minutes, the presentation was repeated. No legal advice or specific legal decisions were discussed during the treatment. In addition, these participants received four weekly legal rights education groups offered by the ward social worker which last approximately 30 - 45 minutes.

Individual sessions for the Deficit-Focused Remediation Treatment and Legal Rights Education Control groups were conducted by psychology students who were blind to the study rationale and hypotheses. Each therapist assistant conducted three treatment sessions per patient regardless of group, therefore randomizing the effect of any therapist variables. Additionally, therapist assistants were evaluated at the end of the study by participants in the following areas: Friendliness, comfort level, trustworthiness, helpfulness of therapist, level of interest in patient treatment success, and therapist regard towards the patient. The purpose of this evaluation was to ensure there were no significant differences in therapist variables between the treatment and control groups.

Therapist assistants were formally trained in conducting treatment with the two groups. In the Legal Rights Education Control Group training, treatment assistants began training by sitting in on a weekly legal rights education group session with the ward social worker. This was followed by a one time formal training session where the protocol format and procedure were discussed (since the training did not differ among participants, a team meeting was not necessary each time a new participant enters this group). In the Deficit-Focused Remediation Treatment Group training, an in depth chart review was conducted and a list of competency related deficits was generated for each participant by the principal investigator. This information was summarized, presented, and discussed with each therapist before treatment began with each participant. The summary was presented to the treatment assistants by the study coordinator in a team meeting which was held before treatment began with each participant. The treatment assistants used the checklist and summary of the chart review as a guide during the sessions.

The GCCT-MSH and the BPRS were re-administered and the Bennett criteria re-evaluated post-treatment, or three weeks after baseline. The GCCT-MSH was again administered by a psychologist or psychology graduate student who was blind to the treatment condition of the participant. A mid-treatment BPRS was administered to patients to better track their improvement or lack of improvement in psychiatric symptom severity. This allowed more accurate determination of the role of psychotic symptomatology in competency restoration. After completion of the tests, the participant was read the debriefing statement.

All participants were tested at Feliciana Forensic Facility. The examiner and participant sat in a quiet testing room. Because FFF is a maximum security hospital, it was required that an unarmed security officer accompany the examiner. This officer sat in a corner and was not intrusive in the testing situation.

Results

All data analyses, excluding power analyses and intraclass correlations were conducted using SPSS for Windows, Version 6.0 . Power analyses were conducted using the Power and Precision program (release 1.20, September 29, 1997, Developed by Michael Bornstein, Hannah Rothstein, and Jacob Cohen). Intraclass correlations (ICCs) were calculated in part by SPSS (within subjects ANOVA) and then computing them manually from the within subjects ANOVA results. This method for determining ICCs has been established in the literature and is both a conservative and accurate measure of reliability (Bartko & Carpenter, 1976). All analyses were considered significant at $p < .05$.

Because of the small and unequal sample sizes (N=8 for the Deficit Focused Remediation Treatment group; N=10 for the Legal Rights Education Control group; and N=8 for the Standard Hospital Treatment group) and potential violations of assumptions of normality, nonparametric statistics were used in the data analysis. Parametric tests are the most powerful because they have the strongest or most extensive assumptions, but the meaningfulness of parametric test results depends on how valid the assumptions are, and small sample sizes tend to violate them (Siegel, 1956). Although results of non-parametric statistics may be at higher risk of Type II error (Chassan, 1979), they were considered the most conservative and accurate method for estimating the significance of differences among means given the small sample and consequences of violating assumptions of normality.

Classification Variables

There were no significant differences among the three groups in baseline scores on the GCCT-MSH, the Bennett criteria, the WAIS-R four subtest short form, the BPRS, or demographic variables recorded. Kruskal-Wallis ANOVAs were conducted and yielded no significant differences among the three groups in baseline scores on the GCCT-MSH [$\chi^2=.469$, $df=2$, $p=.791$], Bennett criteria [$\chi^2=1.7$, $df=2$, $p=.419$], WAIS-R four subtest short form [$\chi^2=1.9$, $df=2$, $p=.394$], or BPRS [$\chi^2=1.4$, $df=2$, $p=.488$]. These data are summarized in Table 1 below.

Table 1
Means and Standard Deviations for Baseline Scores on Outcome Measures

Outcome Measure	Group	Baseline Mean and Standard Deviations (in parentheses)
GCCT-MSH	SHT	65.25 (13.7)
	LRE	69.00 (12.3)
	DFRT	68.00 (6.3)
	Total	67.54 (11.0)
Bennett criteria	SHT	6.88 (3.5)
	LRE	7.00 (3.4)
	DFRT	8.87 (3.6)
	Total	7.54 (3.5)
WAIS-R	SHT	71.75 (9.8)
	LRE	78.10 (8.6)
	DFRT	76.50 (14.6)
	Total	75.65 (11.0)
BPRS	SHT	38.88 (9.7)
	LRE	39.80 (7.4)
	DFRT	45.50 (11.3)
	Total	41.27 (9.5)

Additionally, Kruskal-Wallis ANOVAs were conducted, and yielded no significant differences among the three groups at baseline on any of the demographic variables collected: Age [$\chi^2=1.8$, $df=2$, $p=.409$], axis I diagnosis [$\chi^2=3.3$, $df=2$, $p=.189$], axis II diagnosis [$\chi^2=.73$, $df=2$, $p=.696$], drug use at the time of the crime [$\chi^2=.08$, $df=2$, $p=.860$], education [$\chi^2=2.2$, $df=2$, $p=.330$], employment at the time of the crime [$\chi^2=.08$, $df=2$, $p=.960$], marital status [$\chi^2=.94$, $df=2$, $p=.625$], previous number of criminal charges [$\chi^2=.1$, $df=2$, $p=.951$], and race [$\chi^2=.397$, $df=2$, $p=.963$].

The mean age of subjects was 37 years. 73% were African-American and 27% were Caucasian. Average years of education were 9.5. 88% were not married. 71% had more than five previous criminal charges, while 29% had less than five previous charges. This was the first criminal charge for only one subject. Only 15% of subjects were employed at the time of the arrest. 44% were using drugs and/or alcohol at the time of the arrest. Finally, 77% of subjects in this study carried a diagnosis of a psychotic disorder or Bipolar Disorder, 54% of subjects were diagnosed with a substance abuse or dependence disorder, and 11.5% of participants were diagnosed with a personality disorder. Data are summarized in Tables 2 and 3 below.

Table 2

Means and Standard Deviations for Baseline Scores on Demographic Variables

Demographic Variable	Group	Baseline Mean and Standard Deviations (in parentheses)
Age	SHT	33.6 (6.2)
	LRE	39.3 (9.1)
	DFRT	37.1 (6.6)
	Total	36.9 (7.7)
Years of Education	SHT	8.8 (2.9)
	LRE	10.3 (2.1)

(table con'd.)

DFRT	8.9 (2.5)
Total	9.5 (2.4)

Table 3
Summary of Primary Diagnoses and Charges

Diagnosis	Number of Participants Percentages (in parentheses)
Schizophrenia and Other Psychotic Disorders	16 (61.5%)
Mood Disorders -	
Major Depressive Disorder	4 (15%)
Bipolar Disorder	4 (15%)
Sexual Disorder	1 (.4%)
Personality Disorders	3 (11.5%)
Substance Related Disorders	14 (54%)

*One subject did not carry an Axis I diagnosis

Primary Charges	Number of Subjects
Battery/Assault	10
Burglary/Theft/Robbery	9
Drug charges	4
Attempted murder	3
Resisting arrest	3
Rape	2
Criminal Damage to Property	2
Carjacking	2
Illegal possession of stolen goods	2
Murder	1
Arson	1
Stalking	1
Improper telephone communication	1
Manufacturing and possession of bomb	1

* Many subjects carried more than one criminal charge

Hypothesis One

Hypothesis one stated there would be significant within group pretest/posttest differences on the GCCT-MSH and the Bennett criteria for both the DFRT group and the LRE group. It was also hypothesized there would be no significant within group, pretest/posttest differences in the SHT group on the

GCCT-MSH and the Bennett criteria. The first two parts of this hypothesis were supported but the third was not. Wilcoxon Signed Ranks Tests (for dependent means) yielded significant within group pretest/posttest differences for all three conditions on both the GCCT-MSH and Bennett criteria, respectively: DFRT group [GCCT-MSH: $Z=-2.5$; $p=.012$; Bennett criteria: $Z=-2.5$; $p=.012$]; LRE group [GCCT-MSH: $Z=-2.7$; $p=.007$; Bennett criteria: $Z=-2.8$; $p=.005$]; SHT group [GCCT-MSH: $Z=-2.2$; $p=.025$; Bennett criteria: $Z=-2.2$; $p=.027$]. Data are summarized in Table 4 below.

Table 4
Means and Standard Deviations (in parentheses) for Posttest - Baseline Scores on the GCCT-MSH and Bennett criteria

Outcome Measure	Group	Mean Posttest - Baseline Scores and Standard Deviation (in parentheses)
GCCT-MSH	SHT	9 (9.1)
	LRE	17.4 (9.7)
	DFRT	25.3 (7.8)
	Total	17.2 (10.8)
Bennett criteria	SHT	3 (2.6)
	LRE	6.4 (3.8)
	DFRT	6.1 (3.5)
	Total	5.3 (3.6)

Hypothesis Two

Hypothesis two stated that the DFRT and LRE groups would have significantly higher post treatment scores on the GCCT-MSH and the Bennett criteria than the SHT group. This hypothesis was supported. Kruskal-Wallis ANOVAs were conducted to detect whether significant differences existed among the three conditions on each competency measure. This was significant for both the GCCT-MSH [$\chi^2=10.3$; $df=2$; $p=.006$] and the Bennett criteria [$\chi^2=10.3$; $df=2$;

$p=.006$]. Mann-Whitney U tests (independent sample t-test) were then conducted to determine between which pairs of groups there were significant differences. On the GCCT-MSH, the DFRT group obtained significantly higher post treatment scores than the SHT group [$U=2.5$; $p=.001$] as did the LRE group [$U=16.5$; $p=.034$]. On the Bennett criteria, the DFRT group obtained significantly higher post treatment scores than the SHT group [$U=4.5$; $p=.002$] as did the LRE group [$U=15.5$; $p=.027$].

Hypothesis Three

The third hypothesis stated the DFRT group would achieve significantly greater post treatment scores on the GCCT-MSH and the Bennett criteria than the LRE group. This hypothesis was not supported. Mann-Whitney tests yielded no significant differences between the two groups on either the GCCT-MSH [$U=26$; $p=.237$] or the Bennett criteria [$U=23.5$; $p=.146$]. Data from hypotheses 3 and 4 are summarized in figures 1 and 2, and in tables 5, 6, and 7.

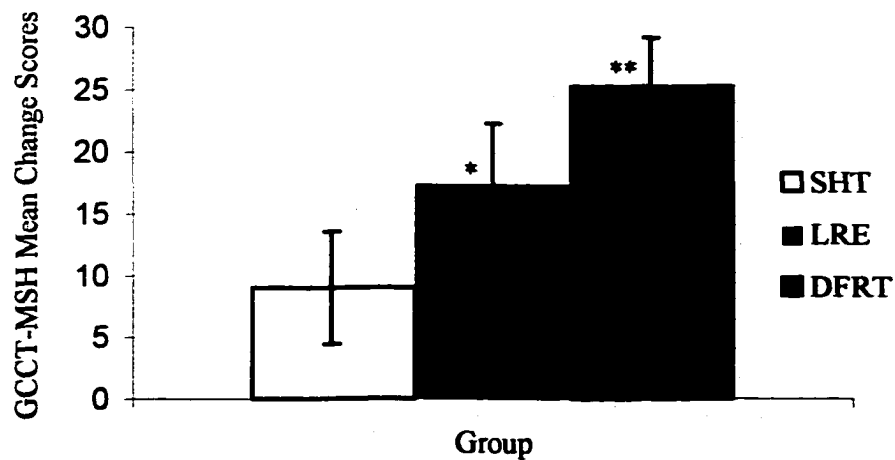


Figure 1. Mean GCCT-MSH Change Scores (Post-Treatment minus Baseline) for the Three Groups.

*Significantly greater than SHT group at $p<.05$.

**Significantly greater than SHT group at $p<.01$.

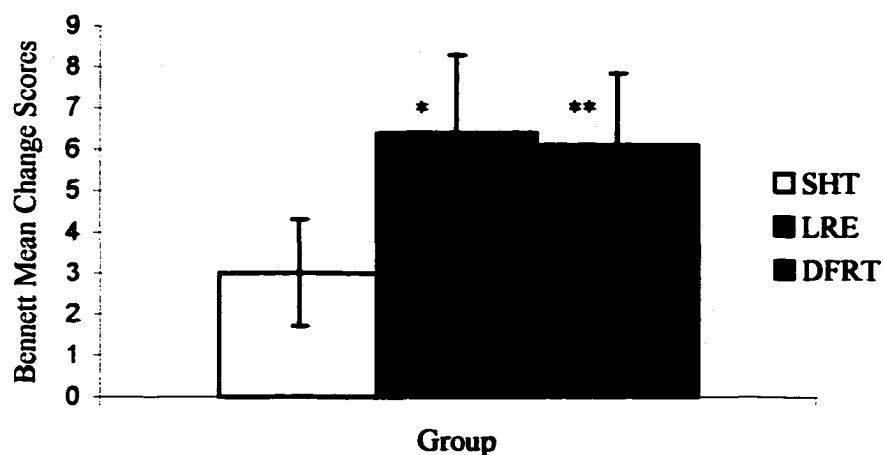


Figure 2. Mean Bennett Criteria Change Scores (Post-Treatment minus Baseline) for the Three Groups

*Significantly greater than SHT group at $p < .05$.

**Significantly greater than SHT group at $p < .01$.

Table 5
Means and Standard Deviations for Posttest Scores on Outcome Measures

Outcome Measure	Group	Posttest Mean and Standard Deviations (in parentheses)
GCCT-MSH	SHT	74.25 (11.9)
	LRE	86.40 (11.7)
	DFRT	93.25 (5.0)
	Total	84.77 (12.5)
Bennett Criteria	SHT	9.88 (4.1)
	LRE	13.4 (3.1)
	DFRT	15.0 (1.8)
	Total	12.8 (3.7)

Table 6

Summary of Baseline and Post-treatment GCCT-MSH Percentage Scores (% correct out of 100 point scale) for Individual Subjects

Standard Hospital Treatment [SHT]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	62	58	-4
2	38	58	20
3	72	78	6
4	72	78	6
5	82	90	8
6	76	78	2
7	62	86	24
8	58	68	10
			Mean % change = 9

Legal Rights Education [LRE]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	72	96	24
2	50	62	12
3	80	100	20
4	58	88	30
5	86	96	10
6	76	74	-2
7	52	82	30
8	64	82	18
9	76	90	14
10	76	94	18
			Mean % change = 17.4

Deficit Focused Remediation Treatment [DFRT]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	72	100	28
2	66	96	30
3	58	92	34
4	66	100	34
5	64	86	22
6	74	92	18
7	78	90	12
8	66	90	24
			Mean % change = 25.3

Table 7

Summary of Baseline and Post-treatment Bennett Scores for Individual Subjects
(In parentheses = % correct out of 16 point scale)

Standard Hospital Treatment [SHT]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	1 (6)	1 (6)	0
2	3 (19)	8 (50)	31.3
3	10 (63)	12 (75)	12.5
4	5 (31)	13 (81)	50
5	10 (63)	13 (81)	18.8
6	10 (63)	10 (63)	0
7	7 (44)	11 (69)	25
8	9 (56)	12 (75)	19
			Mean % change = 19.6

Legal Rights Education [LRE]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	5 (31)	16 (100)	68.8
2	4 (25)	6 (37.5)	12.5
3	7 (44)	15 (94)	50
4	10 (63)	12 (75)	12.5
5	10 (63)	15 (94)	31.3
6	13 (81)	16 (100)	18.8
7	2 (12.5)	15 (94)	81.3
8	6 (37.5)	11 (69)	31.3
9	4 (25)	13 (81)	56.3
10	9 (56)	15 (94)	37.5
			Mean % change = 40

Deficit Focused Remediation Treatment [DFRT]:

<u>Subject #</u>	<u>Baseline Score(%)</u>	<u>Post-Tx Score(%)</u>	<u>% Improvement</u>
1	5 (31)	16 (100)	68.8
2	7 (44)	16 (100)	56.3
3	6 (37.5)	16 (100)	62.5
4	14 (87.5)	16 (100)	12.5
5	5 (31)	11 (69)	37.5
6	13 (81)	16 (100)	18.8
7	11 (69)	14 (87.5)	18.8
8	10 (62.5)	15 (94)	31.3
			Mean % change = 38.3

Hypothesis Four

As pretrial incompetency most often results from unremitting psychotic symptoms (Grisso, 1988), it was hypothesized that there would be a significant correlation between degree of treatment response in the DFRT and in the LRE groups with BPRS change scores. This hypothesis was not supported. To answer this question, the DFRT and LRE groups were combined for analyses, and the SHT control group was excluded. The two groups were combined because the hypothesis did not include making comparisons between the groups. The SHT control group was excluded because this group did not receive active treatment (other than four weekly legal rights groups), and although this group did achieve significantly greater scores between baseline and posttest, their performance on the GCCT-MSH and Bennett criteria was significantly less than the other two groups.

In data analysis, the residual scores from the GCCT-MSH, Bennett criteria, and BPRS were correlated rather than change scores, which are less reliable. Change scores assume there is a perfect correlation between baseline and post treatment test scores, where as residual scores are derived from the actual correlation between baseline and post treatment test scores. Residual scores were calculated by performing regression analyses using baseline competency measure scores as the predictor or constant and using the posttest competency measure scores as the dependent variable. Because there is more error variance when analyzing data with change scores, they are a less reliable dependent variable than residual scores (Winer, 1971).

Therefore, Spearman rank correlations were performed between the GCCT-MSH residual scores and the BPRS residual scores, and between the Bennett

criteria residual scores and the BPRS residual scores. Results indicated no significant correlations between GCCT-MSH and BPRS residual scores [$r_s = -.201$; $p = .423$] or between Bennett criteria and BPRS residual scores [$r_s = -.024$; $p = .924$].

Additionally, GCCT-MSH and Bennett criteria residual scores were correlated with baseline BPRS scores to determine if there were a significant relationship between treatment response and initial level of psychopathology. Spearman rank correlations were performed and results indicated no significant correlation between GCCT-MSH residual scores and baseline BPRS [$r_s = -.154$; $p = .540$] or between Bennett criteria residual scores and baseline BPRS [$r_s = -.204$; $p = .417$].

Data are summarized in table 8 below:

Table 8
Spearman rho Correlation Coefficients for Outcome Measures and BPRS

<u>Scores correlated</u>	<u>r_s</u>	<u>p value</u>
Residual scores of GCCT-MSH & residual scores of BPRS	.201	.423
Residual scores of Bennett criteria & residual scores of BPRS	-.024	.924
Residual scores of GCCT-MSH & baseline BPRS scores	-.154	.540
Residual scores of Bennett criteria & baseline BPRS scores	-.204	.417

Prediction of Treatment Efficacy

To determine whether any defendant characteristics were significantly related to degree of treatment success, the DFRT group and the LRE group were again combined and correlated with, and compared on demographic variables.

Two procedures were used. For continuous variables, Spearman rank correlations were conducted; there were no significant correlations between the residual scores on the GCCT-MSH and age [$r_s = .253$; $p = .311$], education level [$r_s = .068$; $p = .797$], or IQ [$r_s = .297$; $p = .232$], and no significant correlations between the residual

scores on the Bennett criteria and age [$r_s=.203$; $p=.418$], education level [$r_s=-.125$; $p=.632$], or IQ [$r_s=.331$; $p=.179$].

For dichotomous variables, Mann-Whitney t-tests (for independent means) were conducted comparing the dichotomous demographic variables on the residual scores for both the GCCT-MSH and the Bennett criteria. Analyses on the residual scores of the GCCT-MSH yielded no significant differences for the variables of psychosis/no psychosis [$U=7$; $p=.066$], personality disorder diagnosis/no personality disorder diagnosis [$U=.000$; $p=.101$], drug use at the time of alleged crime/no drug use [$U=27$; $p=.435$], employment status at the time of alleged crime [$U=26$; $p=.832$], marital status [$U=11$; $p=.482$], or race [$U=22$; $p=.301$]. Mann-Whitney tests yielded significant differences in GCCT-MSH residual scores for individuals who had more than 5 previous criminal charges versus those who had less than 5 [$U=3$; $p=.013$]; subjects with more than 5 previous criminal charges had greater change.

Mann-Whitney tests comparing residual scores of the Bennett criteria to the dichotomous demographic variables yielded very similar results to those observed for GCCT-MSH residual scores. There were no significant differences in Bennett scores for the variables of psychosis/no psychosis [$U=12$; $p=.213$], personality disorder diagnosis/no personality disorder diagnosis [$U=5$; $p=.499$], drug use at the time of alleged crime/no drug use [$U=23.5$; $p=.261$], employment status at the time of alleged crime [$U=25$; $p=.75$], marital status [$U=14$; $p=.778$], or race [$U=28.5$; $p=.693$]. Mann-Whitney tests yielded significant differences in Bennett criteria residual scores for individuals who had more than 5 previous

criminal charges versus those who had less than 5 [$U=7$; $p=.05$]; subjects with more than 5 previous criminal charges had greater change.

Interrater reliability

Three graduate students participated in administering the BPRS during this study. One of the raters was deemed the expert rater because of extensive training with expert raters at UCLA. The three students rated three separate BPRS scales, which were videotaped, and intra-class correlations (ICCs) were conducted to determine reliability. The average correlation of the two raters' judgments (rater 2 and 3) with the expert rater (rater 1) was .79. The average correlation of raters 2 and 3 was .90.

Two graduate students participated in administering the GCCT-MSH & Bennett criteria during the study. The two graduate students rated two separate GCCT-MSH and Bennett criteria competency measures which were administered, and also rated, by the supervising psychologist, Dr. David Hale. Dr. Hale was deemed the expert rater because of his extensive experience administering competency evaluations as well as the fact he trained the raters in administering these measures. Kappa agreement was determined for both measures. The average correlation of the two raters' judgments with the expert rater was .88 for the GCCT-MSH and .90 for the Bennett criteria.

Therapist Evaluation

Participants were asked by the study coordinator to evaluate each therapist at the end of the treatment protocol. The following areas were rated using a 5 point anchored Likert scale: Friendliness, comfort level, trustworthiness, helpfulness of therapist, level of interest in patient treatment

success, and therapist regard towards the patient. Each subject rated the two therapists on each of these six variables. In this analysis, the two therapist evaluations completed by each patient were combined for the DFRT group and compared to the combined therapist evaluations for the LRE group. The purpose of this evaluation was to evaluate whether there were significant differences in therapist variables between the treatment and control groups. Mann-Whitney tests were conducted to determine whether there were significant differences in any of the six therapist variables between the DFRT and the LRE groups. The analyses indicated no significant differences between the two groups on any of the variables measured: Friendliness [U=32.5; p=.491], comfort level [U=32;p=.444], trustworthiness [U=30;p=.326, helpfulness of therapist [U=24.5;p=.136], level of interest in patient treatment success [U=35.5;p=.676], and therapist regard towards the patient [U=38;p=.853]. Means and standard deviations for each group are summarized in table 9.

Table 9
Mean Scores and Standard Deviations for the DFRT and LRE Groups on
 Therapist Evaluation by Subjects

<u>Area Rated by Subject</u>	<u>Mean(SD) DFRT group</u>	<u>Mean(SD) LRE group</u>
1) Friendliness	8 (1.6)	8.5 (1.5)
2) Comfort Level	8.9 (1.5)	8.4 (1.7)
3) Trustworthiness	9 (1.7)	8.5 (1.7)
4) Helpfulness of the Therapist	9.1 (1.2)	8.1 (1.4)
5) Level of Interest in Patient Treatment Success	8.5 (1.7)	8.3 (1.4)
6) Therapist Regard towards the Patient	8.5 (1.7)	8.5 (1.3)

*The Likert scale was five points, however, each subject rated two therapists which allowed for maximum 10 points per area.

Power Analyses

Preliminary power analyses were conducted to determine the probability of detecting meaningful differences. These analyses assumed $\alpha = .05$, two-tailed tests and 15 subjects in each group. These analyses revealed that given a large effect size, there would be a 76% probability of detecting a significant difference among the three groups.

Power analyses were also conducted at the end of this study to determine probability of detecting meaningful differences using a sample size of 10 per group. Power estimates were then adjusted using Siegel's (1956) estimates of efficiency relative to parametric tests. Power first was determined using Cohen's estimates which are standard and widely used. According to Cohen's estimates, a large effect size is considered to be 0.8 standard deviation, and all estimates were based on a large effect size. Based on sample size of 10 per group, power was estimated at 55% for ANCOVAs, 44% for ANOVAs, and ranged from 45% to 60% for paired t-tests depending on the expected correlation between groups. Power estimates were then determined for non-parametric analogues based on Siegel's (1956) efficiency ratings relative to parametric tests. Power estimates yielded 52% chance of detecting significant differences among the three groups using the Kruskal-Wallis in place of ANCOVA, 42% chance using Kruskal-Wallis and Mann-Whitney tests in place of ANOVAs, and between 42.8% and 57% using Wilcoxon Signed Rank tests in place of paired sample t-tests (depending on expected correlations among the three groups). Power estimates were also calculated by using Pearson product moment correlations for $N=18$ total, which yielded 60%. Power estimates were then determined for non-

parametric analogues based on Siegel's (1956) efficiency ratings relative to parametric tests. Power estimates yielded 54.6% chance of detecting significant correlations using the Spearman rho correlation procedure as a non-parametric analogue. Power analyses for parametric and nonparametric analogues are summarized in table 10 below.

Table 10
Summary of Power Estimates for Parametric Tests and Corresponding Nonparametric Statistical Tests used in Data Analysis

PARAMETRIC TESTS			NONPARAMETRIC TESTS			
Hypothesis #) Test	p value	Power Estimate*	Test	p value	Efficiency relative to parametric statistics**	Power Estimate
(Hypothesis 1) <u>ANOVAs:</u> 1.GCCT- MSH 2.Bennett 3.WAIS-R 4.BPRS	.778	.44	Kruskal- Wallis: 1.GCCT- MSH 2.Bennett 3.WAIS-R 4.BPRS	.791	95.5%	.42
	.445			.419		
	.480			.394		
	.326			.488		
(Hypothesis 2) <u>Paired Samples T-Tests:</u> 1.GCCT- MSH DFRT group LRE group SHT group 2.Bennett DFRT group LRE group SHT group		45% - 60%	Wilcoxon Signed Rank Tests: 1.GCCT- MSH DFRT group LRE group SHT group 2. Bennett DFRT group LRE group SHT group		95%	42.8%- 57%
	<.001			.012		
	<.001			.007		
	.027			.025		
	.002			.012		
	.000			.005		
	.012			.027		

(table con'd.)

Hypothesis #) Test	p value	Power Estimate*	Test	p value	Efficiency relative to parametric statistics**	Power Estimate
(Hypotheses #3 & #4)						
<u>ANCOVAs:</u>			<u>Kruskal-Wallis:</u>			
1.GCCT-MSH	.001	.55	1.GCCT-MSH	.006	95.5%	.52
2.Bennett	.014		2.Bennett	.006		
<u>ANOVAs on Residuals:</u>						
1.GCCT-MSH						
Main effect	.001	.44	<u>Mann-Whitney tests:</u>		95%	.42
<u>Tukey post-hoc tests:</u>			1.GCCT-MSH			
DFRT vs. SHT	.001		DFRT vs. SHT	.001		
LRE vs. SHT	.038		LRE vs. SHT	.034		
DFRT vs. LRE	.124		DFRT vs. LRE	.237		
2. Bennett			2. Bennett			
Main effect	.013					
<u>Tukey post-hoc tests:</u>						
DFRT vs. SHT	.018		DFRT vs. SHT	.002		
LRE vs. SHT	.036		LRE vs. SHT	.027		
DFRT vs. LRE	.886		DFRT vs. LRE	.146		

(table con'd.)

Hypothesis #) Test	p value	Power Estimate*	Test	p value	Efficiency relative to parametric statistics**	Power Estimate
(Hypothesis #5) <u>Pearson correlations:</u> 1.GCCT-MSH residuals & BPRS residuals $r = .141$ 2.Bennett residuals & BPRS residuals $r = .098$ 3.GCCT-MSH residuals & baseline BPRS $r = .067$ 4.Bennett residuals & baseline BPRS $r = .100$.578 .698 .790 .694	60%	<u>Spearman correlations:</u> 1.GCCT-MSH residuals & BPRS residuals $r_s = -.201$ $r_s = -.024$ $r_s = -.154$ $r_s = -.204$.423 .924 .540 .417	91%	54.6%

*calculated from Cohen's estimates

** estimated as efficiency of non-parametric test (Siegel, 1956)

Explanation of exclusion criteria

There were a total of 236 patients who entered FFF throughout the duration of this study. Of the 236 patients, 76 were not pre-trial, meaning they were either declared not guilty by reason of insanity or met the Lockhart criteria, meaning it was the clinical impression of a multidisciplinary team that the patient was unlikely to be restored to competency within a reasonable period of time (less than 180 days). The remaining 160 patients (68%) entered FFF on a pre-trial status and were deemed incompetent to stand trial. 26 patients (16.3%) entered and completed the study. 29 patients (18%) were either uncooperative with

screening or refused to participate. 12 patients (7.5%) dropped out of the study after agreeing to participate. The remaining 93 patients who did not participate failed to meet inclusion criteria for this study: 42 patients (26.3%) were placed on a "fast track" status; 18 patients (11.3%) were too psychotic based on BPRS criteria; 15 patients (9.4%) were either malingering or suspected of malingering based on initial evaluation; 8 patients (5%) had a WAIS-R four subject short form score below 60; 6 patients (3.8%) were accused of first degree murder; 2 patients (1.3%) had a language barrier; 1 patient (0.6%) did not meet age criteria, and; 1 patient (0.6%) was quarantined. The data are summarized in tables 11 and 12 below.

Table 11 - Summary of Patient Status upon Admission to FFF

<u>ADMISSION STATUS</u>	<u>NUMBER</u>	<u>PERCENT (N=236)</u>
1) Not Guilty by Reason of Insanity	42	17.8
2) Lockhart	34	14.4
3) Pre-trial	160	68

Table 12 - Summary of Pre-trial Patients who were Excluded from this Study (26 of 160 or 16.3% were included)

<u>REASON FOR EXCLUSION</u>	<u>NUMBER</u>	<u>PERCENT (N=160)</u>
1) Fast Track status	42	26.3
2) Too psychotic	18	11.3
3) Refused participation	17	10.6
4) Malingering	15	9.4
5) Dropped out after entering study	12	7.5
6) Unable to assess/ uncooperative	12	7.5
7) WAIS-R too low	8	5
8) First degree murder charge	6	3.8
9) Language barrier	2	1.3
10) Too old	1	.6
11) Quarantined	1	.6%

Dropouts

There were a total of 12 patients who dropped out of the study after agreeing to participate. Six participants had been assigned to the DFRT group and two to the LRE group. Three of remaining four dropped out of the study subsequent to signing consent, but prior to being assigned to a group. The final subject who dropped out was placed on a “fast track” status after admission, but prior to beginning the study. Of the eight dropouts who were assigned to a group, five subjects dropped out very early on in the study. One dropout was declared malingering and was dropped from the study. Another became significantly psychotic during the study (over 40 point increase on the BPRS at mid-treatment) and was excluded at that time. The final dropout was excluded from the study because he experienced a seizure just prior to post-testing.

Discussion

Review of Study Purpose

The present study attempted to evaluate the effectiveness of an individualized treatment protocol on competency restoration in pretrial patients (Deficit-Focused Remediation Treatment group, DFRT) compared to a Legal Rights Education control group (LRE) and a Standard Hospital Treatment control group (SHT). The study attempted to answer the following questions: Does more frequent individual legal competency education training (DFRT and LRE) help these patients attain significantly higher scores on the GCCT-MSH and the Bennett criteria, measures of competency to stand trial, than those who receive group training less frequently (SHT), and; does an individual training program targeting the specific legal competency deficits of the participant, including understanding of the specific legal charges (DFRT), help defendants attain significantly higher scores on the GCCT-MSH and the Bennett criteria than participants who receive only individual general legal rights education (LRE).

Review and Interpretation of Results

In the current study, baseline outcome measures and demographic variables were not significantly different among the three groups. This was very important in that significant baseline differences could have caused differential outcomes among the groups, and thus would have required parametric covariance analyses of the group means, which would have been problematic due to the small group samples.

All three groups demonstrated significant differences between baseline and posttest scores, indicating a significant level of change towards competency.

Based on these results, it appears that even minimal treatment (SHT) can improve competency.

Although all groups improved significantly on competency measures from baseline to post-treatment, the posttest competency scores on both measures for the DFRT group and the LRE group were significantly higher than those of the SHT group. Thus, it may be concluded that more frequent individual attention in legal competency education training resulted in significantly greater scores on measures of competency.

The DFRT group did not have significantly higher posttest competency scores than the LRE group on either outcome measure. By comparing the DFRT group with the LRE group, both equal in frequency of individual attention, the purpose was to determine whether there was an advantage to targeting specific individual competency deficits (DFRT group). Based on the literature on transfer of training (how what is learned in one setting transfers to another setting), it was predicted that the DFRT group would have the greatest improvement in competency because of positive transfer (the degree to which individuals apply knowledge and skills learned in one context to another situation), as only this group learned material directly applicable to each subject's competency deficits, material that was the essence of their later competency hearing (Goldstein & Musicante, 1986; Witherington, 1952; Baldwin & Ford, 1988; Goldstein, 1993; Gick & Holyoak, 1987).

Thus, these data suggest that discussion of individual issues and deficits does not lead to greater scores on competency evaluations than discussion of general legal rights issues.

With regard to psychosis, there was no significant relation between degree of change on BPRS scores and competency outcome measures or between baseline BPRS scores and competency outcome measures. In this study, a two to four week waiting period for stabilization of medications prior to beginning competency restoration treatment was required. Additionally, specific BPRS subscales were employed as cutoffs to define a level of psychotic symptomatology that was acceptable for competency restoration treatment. Results suggest that these two preventive measures may have been effective means of selecting program participants whose treatment outcome was not confounded by their psychotic symptomatology.

Limitations and Study Parameters

The greatest limitation of the current study is the small sample size for each treatment group because it restricted the generalizability of results by increasing the probability of Type I error. To reduce Type I error, nonparametric statistics were used in the data analyses, as they make fewer assumptions and are not biased by the violations of assumptions of normality that tend to occur with smaller samples and would bias parametric statistical analyses. When the nonparametric statistical results were compared to parametric statistical results, however, both sets of analyses yielded the same results. Thus, the tendency for nonparametric statistics to more Type II errors was not evidenced in the present study, and the results are adequately generalizable both in terms of Type I and Type II error.

The small sample size resulted from the failure of a very high proportion of patients to meet the inclusion criteria. Only 16% of all pre-trial patients

participated in this study. Although approximately 26% of the pre-trial sample refused participation, were uncooperative/unable to assess, or dropped out, a factor beyond the control of study parameters, a total of 58% of the pre-trial sample, failed to meet inclusion criteria for a variety of other reasons. The predominant reason for these exclusions was patients being placed on a “fast track” status. It was not expected that this would be an important factor in the current study, as this study was geared towards the “standard” pre-trial patient who, according to previous reports, account for 90% of the pre-trial patients admitted to FFF: Exploration of archival data revealed that only 10% of pre-trial patients admitted to FFF previously had been placed on a “fast track” status. In the current study, only 74% of the pre-trial patients were placed on a “standard track” and 26% of the pre-trial patients were placed on “fast track” status upon admission and thus had to be excluded because “fast track” patients are individuals who, upon admission, are deemed competent to stand trial or are considered very close to competency and typically are discharged from the facility within two weeks.

A change in state policy accounted for this problem. During the past 18 months, there was a statewide effort to increase legal rights training in parish jails while the patients awaited admission to FFF. Specifically, three additional District Coordinators had been hired by the Community Outreach program associated with FFF to cover the Baton Rouge, St. Tammany, and New Orleans areas. District Coordinators offer legal rights education services monthly or biweekly in the parish jails to incompetent defendants. In addition, a full-time employee was hired within the last five months exclusively to offer this type of

training in the parish jails in the New Orleans area, which is where most patients at FFF originate. Thus, more patients arriving at FFF were already deemed competent to stand trial.

Additionally, rigorous exclusion criteria were created to allow broader generalizability of results by ruling out other potentially important confounding variables. The two major exclusionary criteria were severe psychoses and low IQ, which accounted for 16.3% of individuals who were excluded. Previous literature indicated these variables are significant in delaying competency restoration (Grisso, 1988; Nicholson & Kugler, 1991). Two other important exclusion criteria were malingering and a first degree murder charge; malingering and presence of a first degree murder charge may decrease motivation to return to competency as quickly as possible. These individuals accounted for 13% of excluded patients. Taken together, these criteria excluded approximately 29% of individuals who could have been study participants had the criteria been more lenient. However, had these exclusionary criteria been modified, the results might have been uninterpretable. Finally, subjects were required to demonstrate adequate understanding of the purpose of the study, requirements for participation, and risk/benefit ratio. It is likely that this requirement selected higher functioning participants who were more likely to benefit from treatment and regain competency. It is important to note that participants in this study are a random sample of this subset.

Although results of this study suggest that more frequent legal rights education would be a valuable addition to treatment for incompetent defendants, it remains unclear whether the individualized (individual attention) component of the

training was a key variable in positive treatment outcome or whether more intensive (more frequent sessions) training could be conducted as effectively in a group setting. The reason it is unclear is because both DFRT and LRE groups participated in individualized treatment which was more frequent and the SHT group participated in group treatment which was less frequent. It was, however, clear that deficit focused attention was not advantageous as the DFRT and LRE groups did not differ on competency assessment scores.

Applications

A review of the results suggests that subjects in the DFRT and LRE groups improved on competency measures at twice the rate of subjects in the SHT control group. More specifically, individuals in the DFRT group demonstrated a mean increase of 25.3% on the GCCT-MSH and 38.3% on the Bennett criteria, the LRE group exhibited a mean change of 17.4% on the GCCT-MSH and 40% on the Bennett criteria, while the SHT control group, although significantly different from baseline scores, only demonstrated a mean change of 9% on the GCCT-MSH and 19.6% on the Bennett criteria. Thus, both the DFRT and LRE groups demonstrated approximately 50% more improvement on the competency outcome measures than the SHT control group.

As noted previously, it is the goal of the hospital and court system to restore patients to competency in the most expeditious manner possible. From the perspective of the hospital and court systems, it would seem useful to determine the cost of hiring an individual who works exclusively to help restore patients to competency versus the cost of the extended hospital stay of the defendant who receives little or no competency training. From the perspective of the patient, this

service can provide assistance in a speedier return to competency, which is in their best interest because it may prevent a protracted involuntary hospitalization which could potentially exceed the length of time to be served for the criminal charge (Davis, 1985).

In addition, anecdotal information about patients being placed on “fast track” status upon admission lends some nonscientific support to the utility and practicality of tutoring incompetent defendants in the parish jails while they await admission to a forensic facility. For example, in 1997, 1998, and through April of 1999, 15, 19, and 8 patients admitted to FFF were placed on a “fast track”, respectively. If this trend continues, by the end of 1999, it would be expected that 24 patients would have been “fast tracked”. This would be approximately two-thirds more individuals being “fast tracked” than were in 1997, and could potentially decrease length of hospitalization for incompetent defendants as well as costs.

Future Directions

There currently is a paucity of literature in the area of competency restoration. To date, most data have focused on assessment of competency in patients who are adjudicated incompetent to stand trial, with very little emphasis on restoration of competency. At this time, little is known about the effectiveness of procedures for restoring defendants to competency. Because the pretrial population constitutes the largest proportion of psychiatric patients committed to mental hospitals via the United States criminal justice system, and comprises approximately one-third of all admissions to state and federal mental health facilities, it is important that research in the area of treatment of incompetent

defendants continue (Pendelton, 1980; Brown, 1992). Most investigations in recent years have focused on the ability of professionals to predict which defendants will regain pretrial competency, based on demographic variables (Cooper & Grisso, 1996). Given the very low base rate of failure to restore competency, it seems much more productive to dedicate more time to better understanding and improving the treatment of incompetency rather than on predicting outcomes.

Clearly, results of this study demonstrate that more frequent individualized legal rights education is a worthwhile endeavor in treatment of incompetency. Because doing individualized treatment is such a time consuming and exclusionary undertaking, the next practical step in the research arena would be to determine whether more frequent group training would be as effective. The one controlled trial of group treatment geared to competency restoration demonstrated significantly higher scores from pre to posttest for individuals in the treatment group than individuals in the control group (Siegel and Elwork, 1990). This lends support to the idea that group training is effective.

In an optimal research setting, this question could be answered more definitively by creating a research design whereby participants receive treatment in one of four groups. The first group would offer legal rights education in a group setting for a specified number of sessions. Another group would receive legal rights education in a group setting for twice the number of sessions as the first group. The third group would receive legal rights education in an individual setting for the same specified number of sessions as the first group. Finally, the fourth group would receive legal rights education in an individual setting for the

same number of sessions as in the second group. This research design would conclusively evaluate the effects of individualization and frequency of sessions.

In summary, the present study is limited by many of the very real problems which exist in treatment outcome research, especially those caused by ruling out potential confounding variables which thus exclude many potential subjects. Although sample size was small in the current study, results demonstrated the need for more frequent and individualized education and competency training in this population, as well as a need for more research about the best process by which to accomplish competency training. There are still many critical questions which should be addressed, including whether more frequent group treatment or individualized treatment is the most important variable in improving competency training outcomes. Answering these questions will help guide the process by which treaters proceed with competency restoration, and could potentially have very beneficial outcomes for the hospitals, courts, and most importantly, the patient, by providing a speedier restoration to competency.

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Appendix A - Consent Form

Consent Form

Participant Number: _____

1. Title: Effect of an Individualized Treatment Protocol on Competency Restoration in Pre-Trial Forensic Inpatients.

2. Where: Feliciano Forensic Facility

3. Experimenters: You can get in touch with the following people at any time if you have any questions:

Names: Lisa Bertman or Dr. David Hale

Department: Feliciano Forensic Psychology

Telephone Number: (504) 634-2661 Extension 59

4. Purpose of the Study: To determine whether frequent, individualized competency restoration treatment sessions help move patients towards pretrial competency faster than individuals who receive less frequent, less individualized treatment.

5. Participants: This study includes people who have been found by the court to be incompetent to stand trial.

6. Participants who are Excluded: People who are having really bad hallucinations and delusions at the time of the study, people who have major problems with their intellectual functioning, and people who do not want to go back to trial.

7. What's Going to Happen: You will attend individual sessions where you will be given legal rights education two times per week. Each time will take 30-45 minutes and it will last for 3 weeks. So, you will go to a total of six individual sessions where you learn about your legal rights. You will also go to a group session once a week that lasts about 30 minutes. At the end of three weeks, you will be given some tests to see if you are competent to stand trial.

8. Benefits: This study is beneficial for you because it may help you be competent faster so you can go back to court to stand trial.

This will also benefit you because you will get a total of \$6.00 for full cooperation with this study. You will get \$1.00 after the first week of attending the 2 individual sessions and the 1 group session. You will get another \$2.00 after the second week of attending 2 more individual sessions and 1 more group session. You will get another \$3.00 after the third week of attending the final 2 individual sessions and the last group session, and after you take the tests to see if you are competent to stand trial.

9. Risks: There are no medical risks at all to you. If you do not want to go back to trial, this study may be a risk to you because by participating, you may be returned to court faster.

10. Alternatives: Because there is only one study going on, there are no alternatives for you.

11. Right to Refuse: You may not do this study for me if you don't want to, or you can stop doing this study at any time. This will not get you in trouble with the guards or anybody at all. It is completely up to you.

12. Privacy: You will be assigned a participant number when you enter this study. I will put this participant number on all the tests that you are given, and I will not even write your name down on them. The only place your name will be written is on the master list which exists so I can tell which name goes with which number. After we finish the entire study, I will even destroy the form that tells me which person belongs to which tests. This means that your identity will not be revealed at all.

13. Release of Information: I will have to look through your chart to get some information about you like your age, arresting charge, diagnosis, etc.

14. Signatures: I understand that this person has discussed this with me and all my questions have been answered. I understand that if I have any more questions, I can call the people listed above. Also, I can contact the Vice Chancellor of the LSU Office of Research and Economic Development at 388-5833. I agree to all of this, and I have been given a copy of this form.

Signature of the Patient Volunteer

Date

Witness

Date

Investigator(s)

Date

This study subject has indicated to me that the subject is unable to read. I certify that I have read this consent form to the subject and explained that by completing the signature line above, the subject has agreed to participate.

Signature of Reader

Date

Appendix B - Informed Consent Validation Questionnaire

Informed Consent Validation Questionnaire

To make sure that you understand what I went over in the informed consent, I would like to ask you some questions.

A. This question reflects communication of a choice: Have you decided to go along with this treatment? Can you tell me what your decision is?

B. This question reflects factual understanding of the issues: Could you tell me what the purpose of this treatment is? Could you tell me what some of the benefits of this treatment are? What about the risks?

C. This question reflects appreciation of the situation and its consequences: What is a possible outcome(s) of participating in this treatment?

D. This question reflects rational manipulation of information: Tell me how you reached the decision to accept this treatment. What were the factors that were important to you in reaching the decision? What is your overall understanding of the information I presented to you and about your participation in this study?

**Appendix C - Instructions to Legal Rights
Education Group Study Participants**

Instructions to Legal Rights Education Group Study Participants

As I said before, I am trying to see if individual sessions of legal rights education help move you towards competency faster than patients who are not receiving individual sessions. To do this, I need you to come learn about legal rights with me two times a week for about an hour. We will not be discussing your specific charge(s) in these sessions. You also need to go to your legal rights education group that meets once a week with your social worker. I need you to do this for three weeks in a row and then I will give you a test to measure your knowledge about legal rights and will also ask you about some psychiatric symptoms which you may or may not be having (e.g., like hallucinations). If you go to all the sessions the first week, you will receive \$1.00. If you go to all the sessions the second week, you will receive another \$2.00. If you go to all the sessions the third week and take those tests for me, I will give you another \$3.00. So, you only get the money at the end of each week if you give full participation. If you refuse to go to any of these sessions, you will be dropped from the study and will not have the chance to sign back up later. Please understand that by participating in this study, you may go back to court faster than if you do not participate in this study.

**Appendix D - Instructions to Deficit-Focused Remediation Group
Study Participants**

Instructions to Deficit Focused Remediation Group Study Participants

As I said before, I am trying to see if individual sessions of legal rights education help move you towards competency faster than patients who are not receiving individual sessions. To do this, I need you to come learn about legal rights with me two times a week for about an hour. These sessions will focus on your specific deficits and things you are having difficulty understanding about your legal rights. To participate in this group, you must be willing to discuss the charges against you openly with me. You also need to go to your legal rights education group that meets once a week with your social worker. I need you to do this for three weeks in a row and then I will give you a test to measure your knowledge about legal rights and will also ask you about some psychiatric symptoms which you may or may not be having (e.g., like hallucinations). If you go to all the sessions the first week, you will receive \$1.00. If you go to all the sessions the second week, you will receive another \$2.00. If you go to all the sessions the third week and take those tests for me, I will give you another \$3.00. So, you only get the money at the end of each week if you give full participation. If you refuse to go to any of these sessions, you will be dropped from the study and will not have the chance to sign back up later. Please understand that by participating in this study, you may go back to court faster than if you do not participate in this study.

Appendix E - Demographic Questionnaire

Demographic Questionnaire

Participant Number _____

Age _____

Race _____

Education level _____

Marital Status _____

Diagnosis: Axis I _____
 Axis II _____

Charge(s) _____

Number of previous charges _____

Employment at the time of the crime _____

Drug use at the time of the crime _____

Medication(s) _____

Baseline GCCT-MSH score _____
score _____

Post-treatment GCCT-MSH

Baseline Bennett criteria score _____
score _____

Post-treatment Bennett criteria

Baseline BPRS score _____

Mid-treatment BPRS score

Post-treatment BPRS score

Baseline clinical judgment about
about
overall competency status _____

Post-treatment clinical judgment

overall competency status

WAIS-R 4 subtest score _____

**Appendix F - Georgia Court Competency Test - Mississippi State Hospital
(GCCT-MSH)**

GEORGIA COURT COMPETENCY TEST - MSH Revision

Name _____ Examiner _____

Date _____ Age _____ Sex _____ Race _____

Hospital # _____ Charges _____

I. Layout of courtroom/roles of Participants

A. Picture of Court (one point for correct answer)

_____ 1. Where does the judge sit?

_____ 2. Where does the jury sit?

_____ 3. Where will you sit?

(Correct if testee points to either table in front of bench)

_____ 4. Where will your lawyer sit?

(Correct if testee points to the table at which he has indicated he will be seated.)

_____ 5. Where will the District Attorney (Prosecutor) sit?

(Correct if testee points to the table opposite from the one at which he will be seated.)

_____ 6. Where will the witness sit to testify?

_____ 7. Where do the people watching the trial sit?

B. Functions (two point maximum for each question)

_____ 1. What does the Judge do during the trial?

(one point for knowing that the judge keeps order during the trial, or instructs the jury, or makes decisions on points of law, etc.; one point for knowing that he passes sentence. Maximum = 2 points)

_____ 2. What does the jury do?

(two points for knowing that the jury rules the defendant guilty or not guilty)

_____ 3. What will your lawyer do?

(two points for knowing that the lawyer will try to "defend" him/her or will attempt to disprove ["beat"] the charges)

- _____ 4. What will the District Attorney (Prosecutor) do?
(two points for knowing that he will try to get a conviction or "put me in jail")
- _____ 5. What do the witnesses do?
(one point for knowing that witnesses talk to those in the courtroom or two points for knowing that they answer questions about the case)
- _____ 6. What do the people watching the trial do?
(two points for knowing that the audience sits quietly and observes the trial)
- _____ 7. What will you do during the trial?
(two points for knowing that the defendant remains seated and quiet or for knowing that he should do as his attorney tells him)

II. CHARGES/CONSEQUENCES/RECOLLECTION OF EVENTS

C. Ability to assist attorney

- _____ 1. What is your attorney's name?
(one point for correct answer)
- _____ 2. How can you contact him/her?
(two points for knowing phone number, address or some other reasonable means of contact)
- 3 How can you help your lawyer defend you?

0

2

4

6

No answer
or incoherent

States he will
work with lawyer
but does not
state how.

States he will
work with lawyer
by answering his
questions about
the case

States he will
work with lawyer
by answering his
questions and by
telling his side
of the story

D. Charge

1. What are you charged with?

0	1	2	3	4
No answer or totally incorrect	Description of behavior but no charge stated (e.g. "took a car" instead of grand larceny)	Related but incorrect charge (e.g. breaking and entering instead of burglary)	Incomplete or partially correct charge (e.g. assault instead of aggravated assault)	Complete formal charge

2. What does that mean?

0	1	2	3	4
No answer or totally incorrect charge	Incorrectly describes incorrect (e.g. stole a gun as description of assault when charge is kidnapping)	Correctly describes related but of correct charge (e.g. breaking and entering instead of burglary)	Partial or incomplete description of correct charge (e.g. hurting someone instead of murder)	Complete and correct description of charge

3. If the jury finds you guilty on this charge, what might they do to you?

0	1	2	3	4
No answer or totally incorrect	States nothing will happen because.... (e.g. has a good lawyer or didn't do anything wrong)	States that there will be a penalty but has no idea what it will be	Penalty too light or too severe (e.g. 1 yr in prison for murder)	Answer complete and consistent with offense

4. You do not have to answer this question. But if you choose to, I would like you to tell me as much as you can about the events which lead to your arrest?

0	2	4	6	8
No answer or totally incoherent	Vague answer which is difficult to understand or to answer unbelievable or obviously delusional in nature	understandable but inconsistent answer	consistent answer or well-stated decision not	well-stated, consistent answer

BEHAVIORAL OBSERVATIONS

Above 70 = passing
60-70 = marginal
Below 60 = failing

Raw Score X 2 = Final Score

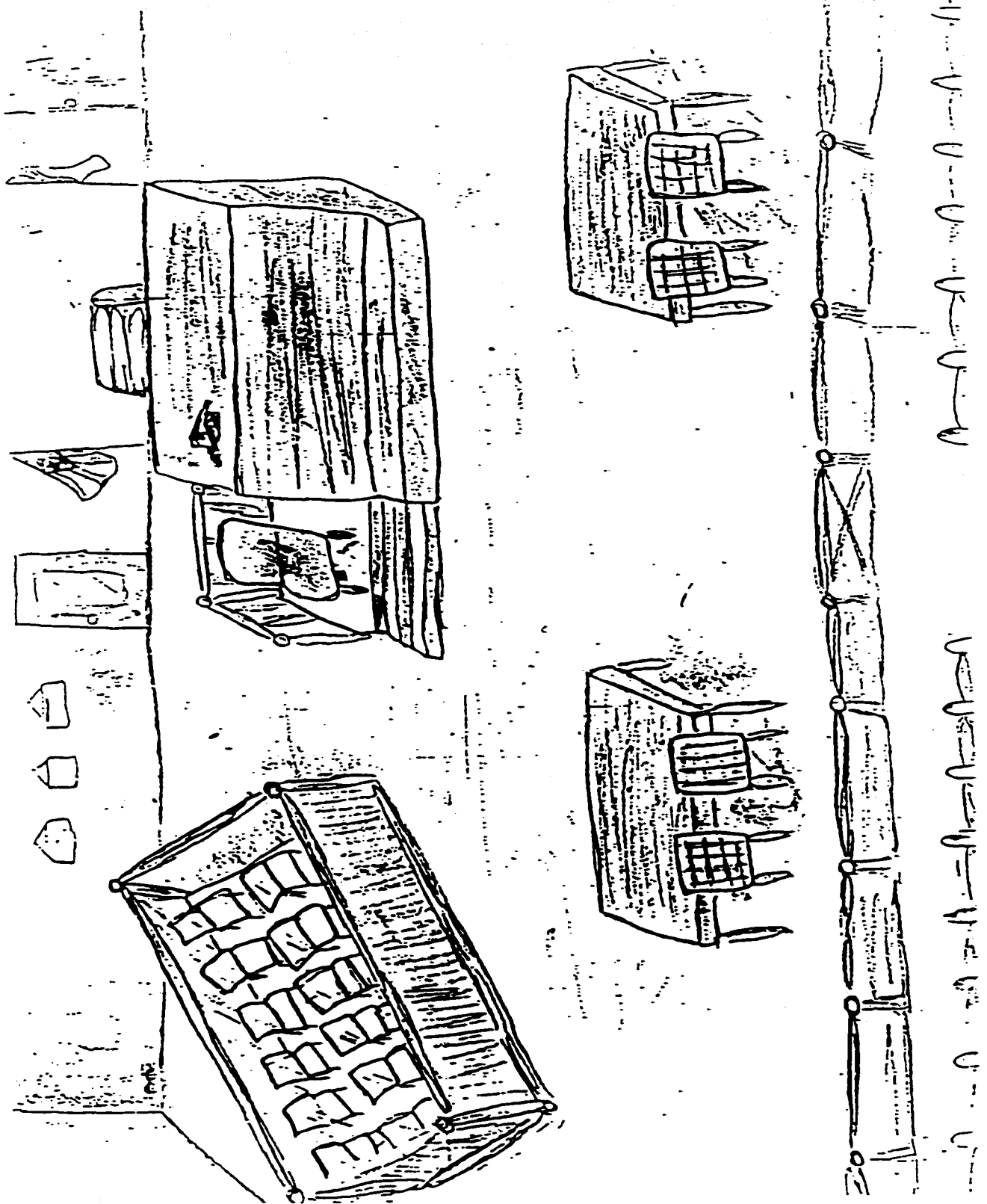
_____ X 2 = _____

GEORGIA COURT COMPETENCY TEST. AP Scale

NO/NO ANSWER	QUALIFIED YES/ SOMETIMES	DEFINITE YES
-----------------	-----------------------------	-----------------

- | | | | |
|---|---|---|---|
| 1. When the lawyers are talking among themselves, are you worried that they might be telling dirty jokes at your expense? | 0 | 1 | 2 |
| 2. When you are in the courtroom, have you become convinced that everyone knew your more private thoughts just by looking at you? | 0 | 1 | 2 |
| 3. Are the judges black robes associated with black magic? | 0 | 1 | 2 |
| 4. Do you often wonder what the court reporter is really thinking? | 0 | 1 | 2 |
| 5. I asked you before about criminal charges. Do you sometimes get confused when they talk about charges against you and start thinking about charges on a credit card or electrical charges? | 0 | 1 | 2 |
| 6. When you talked to the police, did they use mind control to get you to say things against your will? | 0 | 1 | 2 |
| 7. Do you ever worry that most of the people in the courtroom are impostors and that they are just pretending to be who they say they are? | 0 | 1 | 2 |
| 8. Witnesses are asked to swear an oath on the Bible. Do you worry what God might do, if other people were to tell lies on the witness stand? | 0 | 1 | 2 |

TOTAL SCORE _____



Appendix G - Bennett Criteria

PSYCHOLOGICAL CONSULTATION

COMPETENCY ASSESSMENT

Name: _____ Hospital Number: _____ Age: _____

Date of Birth: _____ Race/Sex: _____ Charge: _____

Date of Admission: _____ Status: _____

Parish: _____ Judge: _____

Date of Evaluation: _____

This is in response to the recent request for my opinion regarding whether or not the above mentioned patient is mentally competent to stand trial.

In regard to the defendant's awareness of the nature of the proceedings, I have considered the following during my evaluation with him/her:

Yes No 1. Does he/she understand the nature of the charge(s)?

Yes No 2. Can he/she appreciate it's seriousness?

Yes No 3. Can he/she understand the defense(s) available to him/her?

Yes No 4. Can he/she distinguish between a guilty plea and a not guilty plea?

Yes No 5. Can he/she understand the consequences of either plea?

NAME: _____ HOSPITAL NUMBER: _____

BUILDING/WARD: _____

FFF#: 122

PSYCHOLOGICAL CONSULTATION
COMPETENCY ASSESSMENT
PAGE 2

Yes No 6. Does he/she understand the role of the:

A. Defense Counsel:

B. Prosecuting Attorney:

C. Judge:

D. Jury:

E. Defendant:

F. Witnesses:

Yes No 7. Can he/she understand his/her "legal rights"?

A. Right to choose between trial by jury or trial by judge. _____

B. Right to remain silent. _____

C. Right to have an attorney present. _____

D. Right to have an attorney appointed. _____

E. Right to call witnesses. _____

F. Right to a fair and speedy trial. _____

Yes No 8. Can he/she understand the possible verdicts that a judge or jury may return per the existing charge or charges?

Yes No 9. Can he/she understand the consequences of a conviction?

NAME: _____ HOSPITAL NUMBER: _____

BUILDING/WARD: _____

FFF#: 122

PSYCHOLOGICAL CONSULTATION
COMPETENCY ASSESSMENT
PAGE 3

Regarding his/her ability to assist in his/her defense, I considered the following during the interview:

- | | | | |
|-----|----|----|---|
| Yes | No | 1. | Whether he/she is able to recall and relate facts pertaining to his/her actions and whereabouts at certain times? |
| Yes | No | 2. | Whether he/she is able to assist counsel in locating and examining relevant witnesses? |
| Yes | No | 3. | Whether he/she is able to maintain a consistent defense? |
| Yes | No | 4. | Whether he/she is able to listen to the testimony of witnesses and inform his/her lawyer of any distortions or misstatements? |
| Yes | No | 5. | Whether he/she has the ability to make simple decisions in response to well-explained alternatives? |
| Yes | No | 6. | Whether he/she is capable of testifying in his/her own defense? |
| Yes | No | 7. | What extent, if any, would his/her mental condition be apt to deteriorate under the stress of trial? |

NAME: _____ HOSPITAL NUMBER: _____

BUILDING/WARD: _____

FFFR: 122

PSYCHOLOGICAL CONSULTATION
COMPETENCY ASSESSMENT
PAGE 4

Further, the Georgia Court Competency Test - Mississippi State Hospital Revision was administered.

The Georgia Court Competency Test - Mississippi State Hospital (GCCT) was developed as a quantitative measure that would be easily understood by defendants. It is administered orally, and is designed to sample a defendant's knowledge and skill in the understanding of courtroom procedures, knowledge of the charge, knowledge of possible penalties, and ability to communicate effectively with an attorney. Research has revealed that it correlates very highly with decisions based on intensive evaluations. Scores of 70 and above fall in the competent to stand trial range. Those of 59 and below are in the incompetent range. Scores in the 60 to 69 range are borderline.

The standard score obtained on this administration of GCCT was _____, indicating competency skills in the:

_____ Competent range

_____ Borderline range

_____ Incompetent range

NAME: _____ HOSPITAL NUMBER: _____

BUILDING/WARD: _____

FFF#: 122

RECOMMENDATIONS TO THE COURT

- I. If considered competent to proceed:
- A. Patient is now competent to proceed to trial, based on criteria as outlined in State versus Bennett and results of the GCCT - MSHR.
 - B. Further treatment needed, Specific Bennett and GCCT - MSHR deficits are:
- II. If considered incompetent or unlikely to attain competency in a reasonable time (six months) request Lockhart.
- A. Identified Bennett and GCCT - MSHR deficits pertaining to lack of capacity to proceed are:
 - B. Recommendations to court regarding placement and/or continued treatment.

Psychologist

Date

NAME: _____ HOSPITAL NUMBER: _____

BUILDING/WARD: _____

FFF#: 122

Appendix H - Brief Psychiatric Rating Scale (BPRS)

Brief Psychiatric Rating Scale (Version 4.0)

Name/ID # _____ Date _____ Rater _____
 Hospital/Location _____ Period of assessment _____

NA	1	2	3	4	5	6	7
Not Assessed	Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

Rate items 1-14 on the basis of patient's self-report during interview. Mark "NA" for symptoms not assessed.
 Note items 7, 12, and 13 are also rated on observed behavior during the interview. **PROVIDE EXAMPLES.**

1. Somatic Concern	NA	1	2	3	4	5	6	7
2. Anxiety	NA	1	2	3	4	5	6	7
3. Depression	NA	1	2	3	4	5	6	7
4. Suicidality	NA	1	2	3	4	5	6	7
5. Guilt	NA	1	2	3	4	5	6	7
6. Hostility	NA	1	2	3	4	5	6	7
7. Elevated Mood	NA	1	2	3	4	5	6	7
8. Grandiosity	NA	1	2	3	4	5	6	7
9. Suspiciousness	NA	1	2	3	4	5	6	7
10. Hallucinations	NA	1	2	3	4	5	6	7
11. Unusual Thought Content	NA	1	2	3	4	5	6	7
12. Bizarre Behavior	NA	1	2	3	4	5	6	7
13. Self-neglect	NA	1	2	3	4	5	6	7
14. Disorientation	NA	1	2	3	4	5	6	7

Rate items 15-24 on the basis of observed behavior or speech of the patient during the interview.

15. Conceptual Disorganization	NA	1	2	3	4	5	6	7
16. Blunted Affect	NA	1	2	3	4	5	6	7
17. Emotional Withdrawal	NA	1	2	3	4	5	6	7
18. Motor Retardation	NA	1	2	3	4	5	6	7
19. Tension	NA	1	2	3	4	5	6	7
20. Uncooperativeness	NA	1	2	3	4	5	6	7
21. Excitement	NA	1	2	3	4	5	6	7
22. Distractibility	NA	1	2	3	4	5	6	7
23. Motor Hyperactivity	NA	1	2	3	4	5	6	7
24. Mannerisms and Posturing	NA	1	2	3	4	5	6	7

Sources of information (check all applicable):

☐ Patient
☐ Parents/Relatives
☐ Mental Health Professionals
☐ Chart

Confidence in assessment:

Explain here if validity of assessment is questionable:

☐ Symptoms possibly drug-induced
☐ Underreported due to lack of rapport
☐ Underreported due to negative symptoms
☐ Patient uncooperative
☐ Difficult to assess due to formal thought disorder
☐ Other _____

**Appendix I - Weschler Adult Intelligence Scale
Revised (WAIS-R) - Four-Subtest Short Form**

WAIS-R RECORD FORM

WECHSLER ADULT
INTELLIGENCE SCALE—
REVISED

NAME _____

ADDRESS _____

SEX _____ AGE _____ RACE _____ MARITAL STATUS _____

OCCUPATION _____ EDUCATION _____

PLACE OF TESTING _____ TESTED BY _____

TABLE OF SCALED SCORE EQUIVALENTS*												
Scaled Score	RAW SCORE											Scaled Score
	VERBAL TESTS						PERFORMANCE TESTS					
	Information	Digit Span	Vocabulary	Arithmetic	Comprehension	Similarities	Picture Completion	Picture Arrangement	Block Design	Object Assembly	Digit Symbol	
19	—	28	70	—	32	—	—	—	51	—	93	19
18	29	27	69	—	31	28	—	—	—	41	91-92	18
17	—	26	68	19	—	—	20	20	50	—	89-90	17
16	28	25	66-67	—	30	27	—	—	49	40	84-88	16
15	27	24	65	18	29	26	—	19	47-48	39	79-83	15
14	26	22-23	63-64	17	27-28	25	19	—	44-46	38	75-78	14
13	25	20-21	60-62	16	26	24	—	18	42-43	37	70-74	13
12	23-24	18-19	55-59	15	25	23	18	17	38-41	35-36	66-69	12
11	22	17	52-54	13-14	23-24	22	17	15-16	35-37	34	62-65	11
10	19-21	15-16	47-51	12	21-22	20-21	16	14	31-34	32-33	57-61	10
9	17-18	14	43-46	11	19-20	18-19	15	13	27-30	30-31	53-56	9
8	15-16	12-13	37-42	10	17-18	16-17	14	11-12	23-26	28-29	48-52	8
7	13-14	11	29-36	8-9	14-16	14-15	13	8-10	20-22	24-27	44-47	7
6	9-12	9-10	20-28	6-7	11-13	11-13	11-12	5-7	14-19	21-23	37-43	6
5	6-8	8	14-19	5	8-10	7-10	8-10	3-5	8-13	16-20	33-36	5
4	5	7	11-13	4	6-7	5-6	5-7	2	3-7	13-15	29-29	4
3	4	6	9-10	3	4-5	2-4	3-5	—	2	9-12	16-22	3
2	3	3-5	6-8	1-2	2-3	1	2	1	1	6-8	5-15	2
1	0-2	0-2	0-5	0	0-1	0	C-1	0	0	0-5	0-7	1

*Clinicians who wish to draw a profile may do so by locating the subject's raw scores on the table above and drawing a line to connect them. See Chapter 5 in the Manual for a discussion of the significance of differences between scores on the tests.

	Year	Month	Day
Date Tested	_____	_____	_____
Date of Birth	_____	_____	_____
Age	_____	_____	_____

SUMMARY		
	Raw Score	Scaled Score
VERBAL TESTS		
Information	_____	_____
Digit Span	_____	_____
Vocabulary	_____	_____
Arithmetic	_____	_____
Comprehension	_____	_____
Similarities	_____	_____
Verbal Score	_____	_____
PERFORMANCE TESTS		
Picture Completion	_____	_____
Picture Arrangement	_____	_____
Block Design	_____	_____
Object Assembly	_____	_____
Digit Symbol	_____	_____
Performance Score	_____	_____

	Sum of Scaled Scores	IQ
VERBAL	_____	_____
PERFORMANCE	_____	_____
FULL SCALE	_____	_____



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4. PICTURE ARRANGEMENT <small>Discontinue after 4 consecutive failures beginning with item 2</small>							
Arrangement	Order	Correct or Acceptable Order	Score (Circle)	Arrangement	Order	Correct or Acceptable Order	Score (Circle)
1 House 60"	1	CAP	0 1 2	6 Escape 90"		HUNT	0 2
	2			7 Hill 90"		HELPS	0 2
2. Flint 60"		JANET JNAET or AJNET	0 1 2	8. Fish 90"		ANGLER or ARNGLE AGNLER	0 1 2
3 Romeo 60"		SHADE	0 2	9 Robber 120"		LUNCH	0 2
4 Louie 60"		ARGUES	0 2	10. Taxi 120"		SAMUEL or AMUELS SALMUE	0 1 2
5. Enter 90"		OPENS OENSP	0 1 2				
Note: Be sure to include scores for items 1-5 in Total.							Total <small>Max = 20</small>

5. VOCABULARY <small>Discontinue after 5 consecutive failures.</small>		Score 2, 1, or 0
1. Bed		
2. Ship		
3 Penny		
4. Winter		
5 Breakfast		
6 Repair		
7. Fabric		
8 Assemble		
9 Enormous		
10 Conceal		
11 Sentence		
12 Consume		
13 Regulate		
14 Terminate		
15 Commence		
16 Domestic		
17. Tranquil		
18. Ponder		
19. Designate		
20 Reluctant		
21. Obstruct		
22. Sanctuary		
23. Compassion		
24. Evasive		
25. Remorse		
26. Perimeter		
27. Generate		
28. Matchless		
29 Fortitude		
30 Tangible		
31 Plagiarize		
32 Ominous		
33 Encumber		
34 Audacious		
35 Tirade		
Note: Be sure to include scores for items 1-5 in Total.		Max = 70

6. BLOCK DESIGN Discontinue after 3 consecutive failures							
Design	Time	Pass-Fail	Score (Circle the appropriate score for each design)				
1. 60"	1		2				
	2		2				
2. 60"	1		2				
	2		0				
3. 60"			0	10-20 4	11-15 5	16-20 6	
4. 60"			0	10-20 4	11-15 5	16-20 6	
5. 60"			0	21-25 4	26-30 5	31-35 6	36-40 7
6. 120"			0	36-40 4	41-45 5	46-50 6	51-55 7
7. 120"			0	61-70 4	71-80 5	81-90 6	91-100 7
8. 120"			0	76-80 4	81-85 5	86-90 6	91-95 7
9. 120"			0	76-80 4	81-85 5	86-90 6	91-95 7
						Total	
						Max = 51	

7. ARITHMETIC Discontinue after 4 consecutive failures.						
Problem	Response	Score 1 or 0	Problem	Response	Time	Score (Circle)
1. 15"			10. 60"			0 10-20 1 2
2. 15"			11. 60"			0 10-20 1 2
3. 15"			12. 60"			0 10-20 1 2
4. 15"			13. 60"			0 10-20 1 2
5. 30"			14. 120"			0 10-20 1 2
6. 30"						
7. 30"						
8. 30"						
9. 30"						
						Total
						Max = 19

Note: Be sure to include scores for items 1-9 in Total.

Appendix J - Legal Rights Study Guide

Legal Rights Study Guide

Instructions to professional conducting the legal rights education session: The following areas are discussed in this educational protocol: 1) The three possible pleas and verdicts, and their meaning; 2) The six legal rights of the defendant; 3) The layout of the courtroom; 4) The roles of different people in the courtroom; 5) Ways to assist counsel in the defense; and 6) Plea bargains. This educational training will be presented in a didactic format. The professional conducting the session should present the information and pose questions to the participant in an effort to elicit responses from him. If the participant does not know an answer, the information should be presented to him. All information in this study guide should be presented in each session. If all information is presented before 30-45 minutes, repeat presentation. Individual criminal charges will not be discussed in these sessions.

1) The 3 possible Pleas and Verdicts

- * Guilty
- * Not Guilty
- * Not Guilty by Reason of Insanity

What do the pleas and verdicts mean?

Guilty Plea - I accept the charge and say "I did it".

Guilty Verdict - Based on the evidence, the judge or jury believes I did the crime.

Not Guilty Plea - I am saying "I do not admit to doing the crime." The district attorney must prove to the court I am guilty. I am considered innocent until the D.A. proves I am guilty beyond a reasonable doubt.

Not Guilty Verdict - Based on the evidence, the judge or jury decide I did not do the crime.

Not Guilty by Reason of Insanity Plea - I am saying I did the crime, but at the time I was mentally ill and could not tell right from wrong. (Just being high on drugs or alcohol does not count).

Not Guilty by Reason of Insanity Verdict - Based on the evidence, the judge or jury decide I did the crime, but at the time I could not tell right from wrong.

If I am found Not Guilty By Reason of Insanity, and get sent back to Forensic, how long would I have to stay here? It would be at least 6 months, but could be for life. The length of time depends on each patient and how well they progress. Your judge would have to decide it was safe for you to be released.

2) The Six Legal Rights of a Defendant

1. In some cases, the right to choose between a jury trial or a judge trial.
2. The right to remain silent, because anything I say may be used against me in a court of law.
3. The right to have an attorney present.
4. The right to have an attorney appointed to me if I cannot afford one.
5. The right to call witnesses.
6. The right to a fair and speedy trial.

3) The layout of the courtroom: (Present the picture of the courtroom)

Where does the judge sit?
Where does the jury sit?
Where do you sit?
Where does the prosecutor (or D.A.) sit?
Where does the defense attorney sit?
Where do the witnesses sit?
Where do the spectators sit?

4) The roles of people in the courtroom:

Defendant (this means you) - My job is to pay attention in court. If someone says something that is not true, I should immediately let my lawyer know by quietly whispering to him. I should always tell my lawyer the truth so that he can do the best job of representing me.

Judge - He is the boss of the courtroom. He will keep order and make sure everyone follows the rules. He is not on either side, he is neutral. In a judge trial, he will give the verdict. If I am found guilty, the judge will give the sentence. (The only exception is if I have a capital case, in which case the jury will make the sentence.)

Jury - If you choose a jury trial, these 12 people will listen to the evidence presented and will decide on a verdict (guilty, not guilty, not guilty by reason of insanity). All 12 have to agree on the verdict.

Witnesses - A witness gets on the stand and answers questions about the case. The witness could be on your side, or could be a witness for the prosecution (D.A.).

Defense Attorney - This is your lawyer. He will defend you in court. He wants you to "beat the charge" and will try to prove you are either not guilty or not guilty by reason of insanity. You can hire an attorney, but if you cannot afford to, the court will appoint one for you.

District Attorney (D.A.) - He is the prosecutor. He wants to convict you, meaning he wants you to be found guilty of your charge.

5) Ways to assist counsel in the defense.

Should I be totally honest with my lawyer? Yes. Even about facts that could be harmful to you. The best way for your lawyer to help you, is for him to know everything about your case. If he doesn't know all the facts, he may be embarrassed in court and you could lose your case.

What kind of things do I need to remember to tell my lawyer? You should be able to tell your lawyer where you were and what you were doing on the day of your arrest. If there are any witnesses to the case, tell your lawyer their names and how he might locate them. If you were someplace else at the time of the crime, try to remember anything that would prove where you were.

Be sure that you know: Your lawyer's name, how to contact your lawyer, what you have been charged with, and what is the most time a person could get on that charge.

6) Plea Bargains

1) You can agree to plead guilty to a lesser charge and in exchange you might get a lighter sentence. For example, if you were charged with aggravated battery, you might plead guilty to simple battery and get less time.

2) Another way would be to "Cop Out" on your friends. If you can give valuable information about other crimes, the D.A. might give you a shorter sentence.

Appendix K - Deficit-Focused Remediation Checklist

Deficit Focused Remediation Program Checklist

Instructions to professional conducting the treatment session: Information presented in this treatment will target the participant's particular deficits. Thus, the content of each session will vary from participant to participant. The session will focus on two major areas: 1) Open discussion of the defendant's specific charges, their meaning, and possible consequences; and 2) Remediation of the defendant's competency related deficits observed on the GCCT-MSH and the Bennett criteria pretest. A check marked in the box indicates that the participant shows deficiencies in that area. The appropriate remediation for each deficit is listed below. All information should be presented in question form to the participant and an attempt to elicit responses should be made. If the participant clearly does not know the material, then it should be presented to him. Each session will include open discussion of the participant's current criminal charge(s). An extensive chart review should be conducted to obtain all relevant legal information. All deficits should be addressed in each individual session. If all information is presented before 30-45 minutes, repeat presentation. No legal advice or specific legal decisions should be discussed during the treatment.

I. The following client focused information should be presented/discussed in each session:

- ☐ EXISTING CRIMINAL CHARGE(s) AGAINST THE PARTICIPANT
- ☐ MEANING OF THE CHARGE(s)
- ☐ POTENTIAL CONSEQUENCES OF BEING FOUND GUILTY OF THE EXISTING CHARGE(s)
- ☐ EVENTS LEADING TO THE ARREST AND DETAILS OF THE INCIDENT
 1. SITUATION - where/when/why
 2. WITNESSES - name(s), relationship to participant (if any)
 3. PRECIPITATING EVENTS - nature of the interchange, terminating factor of the incident, weapon involved, injury involved
 4. VICTIM(S) - name(s), relationship to patient (if applicable)
 5. EMOTIONS - before, during, and after the event
 6. PREDISPOSING FACTORS - drug use at the time of the crime
 7. LIFE CIRCUMSTANCES - stressors
 8. MENTAL STATUS DURING TIME OF ALLEGED OFFENSE - hallucinations, delusions, medication(s).
- ☐ LAYOUT OF THE COURTROOM

Remediation: Present courtroom picture and ask where the following professionals sit: Judge, jury, defendant, defense attorney, district attorney, witnesses, and people watching the trial. (Discuss specific courtroom layout in defendant's parish if different from standard.)

☐ **ROLES OF PROFESSIONALS IN THE COURTROOM**

Remediation: Discuss the roles of the judge, jury, defense attorney, district attorney, witnesses, people watching the trial, and defendant. (Specify names when appropriate.)

☐ **ABILITY TO ASSIST ATTORNEY**

Remediation: Discuss the name of the defendant's attorney, how to contact him/her, how he can help his lawyer defend him, and information that he should remember to tell his lawyer.

☐ **LEGAL RIGHTS OF THE DEFENDANT**

Remediation: Discuss the six legal rights of a defendant.

☐ **THE AVAILABLE PLEAS/VERDICTS AND THEIR MEANING**

Remediation: Discuss the three available pleas and their meaning. Discuss the meaning/consequences of these verdicts.

☐ **PLEA BARGAINING**

Remediation: Discuss "pleading guilty to a lesser charge" and the concept of "cop out".

Appendix L - Therapist Evaluation Form

- 1) **How friendly was this therapist?**
- | | | | | |
|---------------------|---|-------------------|---|---------------|
| 1 | 2 | 3 | 4 | 5 |
| not friendly at all | | somewhat friendly | | very friendly |
- 2) **How comfortable were you asking the therapist questions?**
- | | | | | |
|------------------------|---|----------------------|---|------------------|
| 1 | 2 | 3 | 4 | 5 |
| not comfortable at all | | somewhat comfortable | | very comfortable |
- 3) **How well did you trust the therapist?**
- | | | | | |
|------------------------|---|----------------------|---|------------------|
| 1 | 2 | 3 | 4 | 5 |
| not trustworthy at all | | somewhat trustworthy | | very trustworthy |
- 4) **How helpful was the therapist during this treatment?**
- | | | | | |
|--------------------|---|------------------|---|--------------|
| 1 | 2 | 3 | 4 | 5 |
| not helpful at all | | somewhat helpful | | very helpful |
- 5) **How concerned was the therapist about my success in this treatment protocol?**
- | | | | | |
|----------------------|---|--------------------|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| not concerned at all | | somewhat concerned | | very concerned |
- 6) **Overall, how much did the therapist seem to like me?**
- | | | | | |
|------------|---|----------|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| not at all | | somewhat | | very much |

Appendix M - Debriefing Statement

Debriefing Statement

As I said before, this study was conducted to help move patients towards competency by giving them individual education about their legal rights. Your participation in this study really helped me out. If you would like to know the results of my study, you can contact Lisa Bertman at (504) 388-8745 or Dr. Hale at extension 59 in about 6 months.

You have already received \$3.00, \$1.00 for the first week and \$2.00 for the second week. Since you did such a good job, I am going to give your social worker an additional \$3.00 for your third week of participation. She will put the money in your account for you to spend as you please.

Do you have any questions for me?

Vita

Lisa Jo Bertman was born in Miami, Florida, in 1967. She went to high school in Baton Rouge and earned a bachelor of arts degree from Newcomb College of Tulane University in 1989. She began the doctoral program in psychology at Louisiana State University in 1992, and earned a master of arts degree in this program in 1994. She completed her pre-doctoral internship in psychology through Harvard Medical School/McLean Hospital. She completed her post-doctoral fellow at the Massachusetts General Hospital Obsessive Compulsive Disorder Institute in Belmont, Massachusetts. She continues working at the Obsessive Compulsive Disorder Institute where she is practicing behavioral therapy and treatment outcome research.


DOCTORAL EXAMINATION AND DISSERTATION REPORT

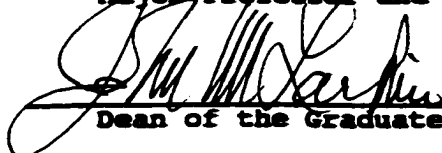
Candidate: Lisa Jo Bertman

Major Field: Psychology


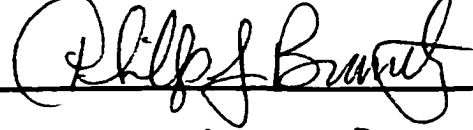
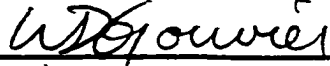
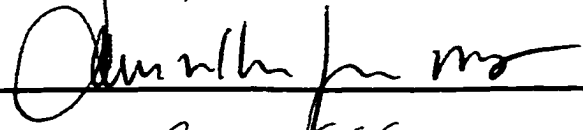
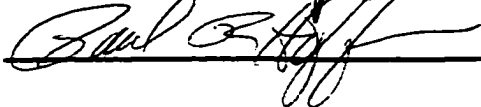
Title of Dissertation: Effect of an Individualized Treatment Protocol on
Competency Restoration in Pretrial Forensic Inpatients

Approved:


Major Professor and Chairman


Dean of the Graduate School

EXAMINING COMMITTEE:

Date of Examination:

July 23, 1999